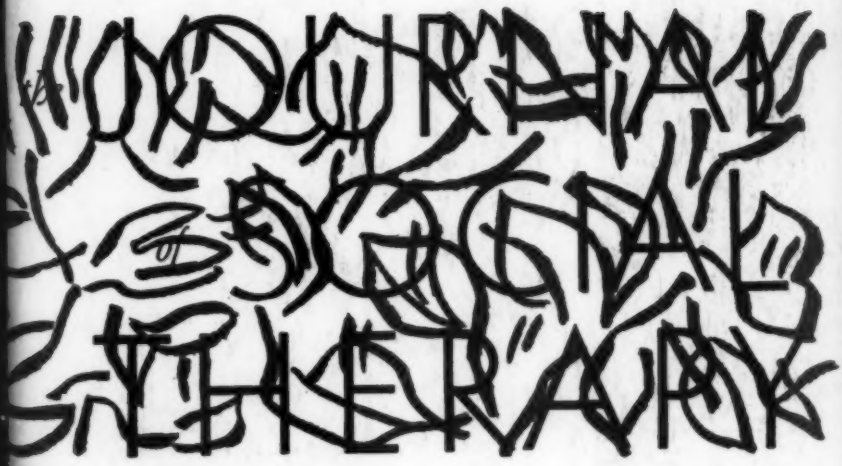

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Let There Be Ecstacy!

THERE was yet so much to wonder over. Winter came, pine branches were torn down in the snow, the green pine needles looked rich upon the ground. There was the wonderful, starry, straight track of a pheasant's footsteps across the snow imprinted so clear; there was the lobbing mark of the rabbit, two holes abreast, two holes following behind; the hare shoved deeper shafts, slanting, and his two hind feet came down together and made one large pit; the cat podded little holes, and birds made a lacy pattern.

Gradually there gathered the feeling of expectation. Christmas was coming. In the shed, at nights, a secret candle was burning, a sound of veiled voices was heard. The boys were learning the old mystery play of St. George and Beelzebub. Twice a week, by lamplight, there was choir practice in the church, for the learning of old carols. Everywhere was a sense of mystery and rousedness. Everybody was preparing for something.

The time came near, the girls were decorating the church, with cold fingers binding holly and fir and yew about the pillars, till a new spirit was in the church, the stone broke out into dark, rich leaf, the arches put forth their buds, and cold flowers rose to blossom in the dim, mystic atmosphere. They must weave mistletoe over the door, and over the screen, and hang a silver dove from a sprig of yew, till dusk came down, and the church was like a grove.

In the cow-shed the boys were blacking their faces for a dress-rehearsal, the turkey hung dead, with opened, speckled wings in the dairy. The time was come to make pies, in readiness.

The expectation grew more tense. The star was risen into the sky, the songs, the carols were ready to hail it. The star was the sign in the sky. Earth too should give a sign. As evening drew on, hearts beat fast with anticipation, hands were full of ready gifts. There were the tremulously expectant words of the church service, the night was past and the morning was come, the gifts were given and received, joy and peace made a flapping of wings in each heart, there was a great burst of carols, the Peace of the World had dawned, strife had passed away, every hand was linked in hand, every heart was singing.

It was bitter, though, that Christmas day, as it drew on to evening, and night, became a sort of bank holiday, flat and stale. The morning was so wonderful, but in the afternoon and evening the ecstacy perished like a nipped thing, like a bud in a false spring. Alas, that Christmas was only a domestic feast, a feast of sweetmeats and toys! Why did not the grown-ups also change their everyday hearts, and give way to ecstacy? Where was the ecstacy?

—*From The Rainbow,* BY D. H. LAWRENCE
(The Viking Press)

May you, too, have much to wonder over as we come to this season of eager preparation and excited anticipation. May this Yuletide sense of mystery and rousedness make every heart again beat fast with expectation. Now is the time to change your everyday heart and give way to ecstacy, sharing in joy and peace. May you have full reason for imperishable ecstacy. That is *The Journal's* wish for all who read this.

SOME PROBLEMS OF THE MENTALLY ILL IN PRISON

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PRISON psychiatry is a neglected field. Few psychiatrists have made it their life work. Governing bodies have seldom been sufficiently enthusiastic or understanding to provide funds and facilities to stimulate wider professional interest. The psychiatrist in other fields is quite likely to believe that the courts screen out those social offenders who are mentally ill and send them to mental hospitals, and that those who get into prison are just scoundrels anyway who can't be treated, especially in the rigid milieu of the average prison. There is nevertheless an increasing awareness that criminal acts are frequently but surface manifestions of profound psychic disturbances, and the past few years have seen a greater interest in persons whose antisocial behavior does not fit the traditional description of the psychotic and who are likewise beyond the legal definition of insanity.

While the greatest concentration of such cases is found in the institution for recidivistic offenders, it is difficult to present a comprehensive psychiatric picture of the population of a major prison. One sees all of the recognized psychiatric conditions, from transient personality disturbances to major psychoses. In prison there is a greater density of abnormal personalities than in almost any other setting, and the peculiar and stressful nature of the prison community itself is productive of bizarre and unusual reaction patterns. The "normal" becomes the unusual, and the eccentric personality pattern the expected. Dramatic neurotic mechanisms and bizarre adaptive behavior patterns are the rule. The sexual deviate, the inadequate, the epileptic, the mentally retarded, the paranoid crank, the borderline schizophrenic and the hysteric are the order of the day. Medical complaints are over

90% psychosomatic; chronic tension headaches, functional gastrointestinal distress, asthenia, insomnia, cardiac anxiety, anorexia, etc., are the meat of daily practice. The hysterical heart attack or convulsive seizure, the confused dissociative episode, the psychophysiological symptom and the homosexual panic reaction are problems met almost daily by the prison practitioner. In short, the prison community is a relatively untapped museum of psychopathology wide open for the student of human personality.

Few major prisons can boast that all of its human material has been thoroughly studied from the psychiatric point of view, and in this respect Leavenworth is no exception. Therefore the following account of some of our experiences is not intended as a scientific dissertation on mental illness but as a presentation of some of the problems encountered by the prison psychiatrist in his daily practice.

THE United States Penitentiary at Leavenworth, Kansas, is a unit of the Federal Prison System designated for the reception of "habitual offenders." It is one of twenty-eight institutions in the system, and receives both direct court commitments from the Middle West as well as transfers from other Federal institutions. The average population during the past decade has been in the neighborhood of 2,300. The mean age of the population during 1955 was 36.5, and the average turnover is about 123 new arrivals per month. In the Federal Service the young offender is sent to the Youth Corrections Institution at Ashland, Kentucky, or to the Industrial School-type institutions at Washington, D.C. and Denver, Colorado. A somewhat older group of youths is committed to the Reformatories, and there is an in-between group of "older improvable offenders" at the medium-security penitentiaries such as those at Terre Haute, Indiana, and Lewisburg, Pennsylvania. Leavenworth receives mostly recidivists in the older age groups, most of them with two or three or even more sentences behind them. Young Federal offenders may begin their sentences at one of the lesser institutions and be graduated up the line, so to speak, to Leavenworth as a result of progressive behavior deterioration. It is occasionally the last point west on the road to Alcatraz, or a temporary holding station for further psychiatric evaluation in borderline cases.

The psychiatric program at Leavenworth is a part of the general medical program, staffed and supervised by United States Public Health Service personnel. There is a 142-bed general hospital, with a thirty-six-bed, well-segregated psychiatric unit, containing two twelve-

bed wards, eight private rooms and five restraint rooms. The full-time professional staff consists of four medical officers, two dental officers and one clinical psychologist. In accordance with current Bureau of Prisons policy, all newly arriving prisoners do *not* receive a psychiatric or psychological examination. Prisoners are seen for initial psychiatric study only on referral from the social service department, the chief disciplinary officer, the trial court, the classification committee; or on the basis of history of mental illness, or obvious psychiatric symptomatology appearing during the initial medical and social processing. In addition, functioning as an integral unit of the general medical program, referrals are constantly being received from the other clinics. During the fiscal year 1956, 178 prisoners* were hospitalized in the psychiatric unit for diagnosis, treatment and disposition, classified as follows:

Epilepsy-Grand Mal	3
Chronic brain syndrome	3
Psychosis with C.N.S. syphilis	2
Psychotic depressive reaction	4
Schizophrenic reactions (all types)	40
Psychoneurotic reactions	37
Personality disorders (all types)	64
Mental deficiency	12
Transient situational personality disturbances	10
Without mental disorder	3
Total	178

Patients with active major mental illnesses are not retained at Leavenworth for long-term therapy. Those with conditions falling within this category are transferred, after certification as being "of unsound mind," by a board of examiners, to the Psychiatric Division of the United States Medical Center for Federal Prisoners at Springfield, Missouri, for prolonged follow-up and care. However, it is by no means possible to transfer all who show psychotic residuals or isolated psychotic symptoms.

The psychiatric in-patient treatment program at Leavenworth consists of hospital seclusion, hydrotherapy, drug therapy, limited psychotherapy and insulin sub-coma. Out-patient follow-up is continued after the patient has been returned to the general population and is back on his job. The tranquilizing drugs, particularly the rauwolfia compounds, have proved to be extremely useful in the management of many of our psychiatric patients. It is the impression of the staff that the unit is quieter and under better control, patients

* There were 55 additional admissions; short-term holdover cases en route to other mental hospitals.

respond better to psychotherapy and there has been a definite lessening of emergency incidents, such as assaults, fights, self-mutilations and destructiveness, and it has been possible to carry along indefinitely some of our minimally disorganized schizophrenics on an out-patient regime of rauwolfia and psychotherapy.

We have the definite feeling, admittedly without actual statistical support, that the number of seriously mentally ill being seen at Leavenworth is increasing somewhat. During the past fiscal year, in addition to two psychotics who were found to be mentally incompetent on arrival and were returned to court for other disposition, fifty-three psychiatric cases required transfer to the Medical Center at Springfield, Missouri, as follows:

Schizophrenic reactions (all types)		30
Simple type	6	
Hebephrenic type	1	
Paranoid type	15	
Acute undifferentiated type	2	
Chronic undifferentiated type	4	
Schizo-affective type	2	
Paranoid state		1
Psychotic depressive reactions		2
Psychosis with brain syndrome		3
Severe psychoneurotic reactions		3
Sexual deviation		7
Other severe personality disorders		2
Grand Mal epilepsy with behavior disorder		3
Parkinsonian, with behavior disorder		2
Total		53

It must be obvious that the above figures do not represent the total of persons needing psychiatric attention at Leavenworth. In the Federal Service, as in most modern penal systems, there is an adequate arrangement for the disposition of the prisoner with a major mental illness. He is identified and through appropriate official channels transferred to a mental hospital equipped for the treatment of such conditions. It is with the lesser borderline psychiatric states that prison psychiatry must be most concerned. In fact, this presentation started out to be a discussion of the problems of the "borderline psychotic" in prison. This title was abandoned because of the difficulty of defining the term "borderline psychotic" and because of the trend in psychiatry to draw away from the concept of "psychosis". "Insanity" is a legal concept implying irresponsibility. A "psychotic" in psychiatry traditionally is a patient afflicted with one of the major mental disorders, but the two have never been synonymous. In psychiatry the dividing line between "insane" and "normal" is not clear and distinct

as required in law. Psychiatry rejects the "either-or" concept and substitutes the doctrine that mental health or responsibility is a matter of degree. Psychiatrists have come to use the term "mentally ill" to include all patients with psychiatric abnormalities who need attention, and there is a trend toward modifying legal concepts to parallel psychiatric concepts more closely. Under the McNaghten rules the ability to distinguish between right and wrong is the basic legal test of insanity, and a person can be quite mentally ill but still legally sane. Changes in the wording of the legal definition appear to be developing which will broaden the legal concept of criminal responsibility and make possible the commitment of a somewhat broader group of social offenders directly from the courts to psychiatric care. The Durham decision in the District of Columbia, the concepts advocated by the Group for the Advancement of Psychiatry, and the work of the American Bar Association toward a more scientifically oriented legal definition of criminal responsibility, all point in this direction.

WHETHER or not the mental hospitals are prepared to receive, detain and treat more of the psychiatrically ill social offenders is something which is not the province of this paper. Nevertheless, experience at an institution for adult habitual offenders such as Leavenworth soon teaches that clinically recognizable psychoses are fairly common among the new arrivals, to say nothing of the much larger group with disabling mental abnormalities below the psychotic level. Whether or not changes in the wording of the legal definition of criminal responsibility will eliminate these remains to be seen. This seems doubtful, at least until such time as the routine psychiatric examination of all persons charged with major crimes is mandatory to a greater extent. Under present circumstances, unless the defense raises the issue of mental competency, psychiatric study of the defendant appears to be uncommon. Pleas of guilty will continue to be accepted from mentally ill individuals whose very mental illness precludes their acquiescence in having the issue raised during trial, unless all offenders are screened. And in those instances where the accused appears eager to have himself recognized as irresponsible and in need of treatment, sound psychiatric judgments are often difficult to reach in the legal atmosphere, unless the court avails itself of pretrial commitment for prolonged observation.

So while the prison psychiatrist must necessarily continue to have some concern with problems of criminal responsibility, his major

interest nevertheless should be with the legally sane offender, the person who cannot be adjudged insane and committed instead to a mental hospital, and must, under the laws of our country, pay the penality for his crime and be sentenced to a penal institution. In the juvenile institutions this constitutes an attempt to treat the personality and behavior disorders. The further "up-the-line" you go in institutional categories the higher is the incidence of mature recidivistic offenders with frozen neurotic character patterns, rigid compulsive anti-social traits, severe long-standing narcotic addiction or alcoholism, paranoid social attitudes and other mental abnormalities at the psychotic or near-psychotic level. It has been said that all crimes have some connection in the unconscious. It has been claimed that all repetitive offenders are mentally ill and that all prisons should be hospitals. Leaving that to the distant future, it is nevertheless true that, exclusive of the classical psychotic, there is a sufficiently high percentage of recidivistic prisoners with recognizable degrees of mental illness that they constitute a treatment problem in all major correctional institutions.

For instance, the so-called simple or ambulatory schizophrenic is quite common in prison. The ambulatory schizophrenic is usually legally sane, and even if identified in court, is seldom found not guilty by reason of mental illness and committed for treatment. Most such individuals adjust fairly well in prison, and many serve several sentences before being recognized or becoming much of a psychiatric or administrative problem, but as they grow older their poor adaptive ability, their intellectual distortions, their seclusiveness and loose reality attachments, bring them to attention and in some cases commitment is eventually necessary. They are the types recognized by disciplinary personnel as eccentric, and they are often referred for psychiatric study at the time of conduct violations. Psychiatric examination will usually reveal their abnormality but, since the mental hospital services available to most prisons are limited, the prison psychiatrist often has little alternative but to conclude that a given patient can serve his sentence without the necessity of formal psychiatric hospital care. In prison they are identified by their proneness to have bizarre physical symptomatology, to be withdrawn and to exhibit mild ideas of reference and eccentric behavior or thinking, but in some instances months and even years of observation and contact may ensue before the proper classification becomes evident. Their capacity for adjustment may be intermittently disrupted by intramural

situational pressures and it is also under these circumstances that they become patients for in-patient psychiatric care in prison. At Leavenworth these disturbed episodes respond fairly well to temporary hospital seclusion, superficial psychotherapy, reassurance and drug therapy, and many are eventually able to return under out-patient guidance to the population for continued program participation. All types of schizophrenic disorders occur in the population of an institution for habitual offenders, varying from the case with nothing more than mild seclusiveness or bizarre somatic ideation to the fully developed paranoid schizophrenic.

IF any one trait can be said to characterize most commonly the inmates of an institution for habitual offenders, it would probably be paranoid ideation of some degree. Paranoid rationalizations are quite common in mankind at large, and it is to be expected that the prison psychiatrist encounters projection mechanisms in a high percentage of recidivistic prisoners. The feeling that the courts have mistreated him, that the institution discriminates against him, or that his criminal pattern has been justified by the events of his life, is so common as to be almost normal in habitual offenders. Hypersuspiciousness, hypersensitivity and a "chip on the shoulder attitude" are frequent. Paranoid shadings vary all the way up to the grossly disoriented paranoid schizophrenic. In between, somewhere on the paranoid scale, is the mature paranoid personality, with his fixed ideas of discrimination, his hostile facade and his litigious activities and rejecting attitude. He files writ after writ in the courts alleging illegal imprisonment or mistreatment; he is the "jail house lawyer", the inventive crank, the disruptive complainer or the medical problem case because of his obsessive ideas of physical disease. The prison psychiatrist is concerned with evaluating the nuances of paranoid coloring in his patients and must constantly be weighing the evidence as to the competency or committability of some of his problem cases.

The far advanced paranoid schizophrenic only rarely finds his way directly into prison, but we seem to be seeing the milder incipient cases more often. The paranoid schizophrenic is quite hostile to the implication that there might be anything wrong with his mental processes and is adept at passing himself off as a responsible person. He wants no sanity hearing at his trial! At Leavenworth recently a far advanced paranoid schizophrenic was received who had pleaded guilty to car theft in order to have himself committed to a Federal

penitentiary, to avoid being returned to California as a violator where "the doctors were plotting to have him executed." Another, on trial home visits from a Veterans' Administration Hospital, was given a maximum sentence for car theft because the hospital report indicated that he was a dangerous paranoid! A third, who eight years earlier had been absolved of responsibility for committing a murder while in the Army in Japan, on the ground of mental incompetence, was thereafter given a dishonorable discharge from the Army, thus preventing his follow-up care by the Veterans' Administration, and resulting in several subsequent criminal offenses and sentences. A fourth had for several years been threatening a doctor who he believed had withheld from him a "secret cure" for his icthyosis, until he was finally apprehended making a threat by long-distance telephone, thus violating a Federal statute.

As prisoners, these paranoid patients, also, in response to intramural situational stresses, go through periods of acute relapse, which sometimes respond well to simple in-patient care, particularly to temporary seclusion and drug therapy. During these disturbed periods they may show reactivation or exacerbation of delusions and hallucinations, and some must be transferred for psychiatric hospital care. Others improve sufficiently to be returned to the population to continue their previous borderline adjustments, often for many years. As stated above, our feeling at Leavenworth is that the borderline paranoid schizophrenic is being received more frequently. If so, could it be because a greater number of mental hospital patients in the last decade are being "cured" and returned to society? Is the modern mental hospital, with its emphasis on the somatic therapies, new drugs, rapid social cure and quick release, and the urge to get the "back ward" patients out, sending more individuals into the general population whose treatment has only forced the major symptomatology into temporary remission, thus increasing the number of persons prone to become involved in criminal violations? The proportion of prisoners at Leavenworth with histories of having been in mental hospitals is fairly high. A survey of the last 500 consecutive admissions revealed that 11.6 per cent gave a history of some type of prior psychiatric confinement; 4.4 per cent in armed services hospitals, 4.2 per cent in state hospitals, and the remaining 3 per cent in other types of institutions, including Veterans' Administration hospitals. Only three cases had been committed for pre-trial observation. A history of definite psychosis was present in 4.4 per cent.

A third commonly seen psychiatric problem case in major penal institutions is the severe hypochrondriacal or anxiety neurotic, the individual who is the despair of the general medical officer as well as the psychiatrist. He is the constant sick-line caller whose compulsive ideas of physical disease dominate his adjustment. He cannot accept the reassurance of repeated diagnostic studies, and is obsessed with the idea that "something is wrong" with him; his symptoms vary from month to month, and situational stresses result in acute exacerbations of his disability. He is convinced that he has heart disease, abdominal malignancy or a genito-urinary disease. Repeated hospitalization on the medical wards occurs. He must be seen daily by the medical officer and given some type of attention. He responds poorly, however, to any type of therapy, including the tranquilizing drugs, insulin sub-coma or psychotherapy. His hypochrondriacalism is a way of life which cannot be changed short of deep analysis, and abortive attempts to provide insight merely change the symptomatology from one bodily system to another or generate extreme hostility. The severe neurotic must remain sick in order to adjust at all. In prison he responds best to periodic retreat into the protective and seclusive environment of the hospital, where he can be nursed and cared for. Treatment of these individuals is poor under the best of circumstances, but some do better if transferred to a mental hospital where their symptoms are not so outstanding and where the milieu is more therapeutically oriented. Of course, all varieties of neurotic symptomatology are quite common in prisoners. In the emotionally immature and unstable types who inhabit such institutions, the stresses of imprisonment are productive of anxiety manifestations of every description. But the prison psychiatrist in managing and treating his neurotic patients recognizes a hard core of deeply fixed neurotic problem cases, often of a hypochrondriacal pattern, whose disposition and management occupy much of his time. He accumulates a few cases with such profound inadequacy and disability, some of whom eventually prove to be classifiable as schizophrenic, that he must regard their severe obsessional symptomatology as grounds for transfer to a special hospital.

PRISONS, of course, are also full of persons who were formerly classified as psychopaths of one variety or another. Changing the terminology to sociopath or personality disorder has not changed the picture, and the prison psychiatrist must still be prepared to manage these individuals during their disturbed episodes and to advise the

administration regarding their disposition. While current psychiatric thinking suggests that most persons classified under this grouping are not truly without recognizable anxiety and guilt, but are "neurotics in disguise," or merely wear a "mask of sanity," the current social concept is that the psychopath belongs in prison and that this is the place to treat and manage him. Whether or not the future holds a more hopeful treatment outlook, at present the prison psychiatrist must continue to see, work with, evaluate and help manage them. The experienced prison psychiatrist knows that the severe hysterical psychopath can be the most difficult management problem in the whole psychiatric category. Their proclivity under stress to exhibit dissociative manifestations, indulge in self-mutilation, or develop bizarre conversion symptoms, provide the prison psychiatrist with his most troublesome problems and the prison disciplinary officer with an excuse to cry for help. The psychopath cannot be ignored. He must be seen and his complaints treated seriously. He can be pushed just so far. His compliance with disciplinary control goes only to a certain point. When completely frustrated by rigid disciplinary attitudes, his hostility is turned inward and he is quite likely to indulge in vicious self-mutilation or develop dramatic hysterical symptoms. A few such persons in prison must be regarded as mentally incompetent and recommended for transfer to mental hospitals. The prison psychiatrist will constantly have under observation and follow-up a group of individuals of this stamp in whom he is trying to weigh the evidence for or against recommendation for commitment. It is surprising how often patients, who for years, and through various sentences, have been regarded as simple personality disorders, eventually turn out to be schizophrenic; and to what extent the entire symptomatology of the mental illnesses in prison is colored by the psychopathic background of the individual patients.

Strangely enough, the true psychotic depressive reaction is uncommon in prison. One might expect that serious depressive reactions to imprisonment would be frequent, but the opposite is true. Mild neurotic depressive states are seen, but they are usually treatable at the local level. The occasional prison suicide of course attests to the fact that all serious depressives are not recognized, but prison reform has tended to reduce their number. Twenty years ago the author was connected with an institution of the rigid character, with a repressive silent system, severe discipline, very limited recreation, few personal privileges, restricted movement and constant close surveillance, where

the suicide rate was about two or three a year. During a recent tour of a large municipal jail it was reported unofficially that suicides occurred at the approximate rate of one a month! At Leavenworth there have been only two suicides in the past six years, and it is the author's impression that the suicide rate in prisons is in inverse proportion to the humanitarianism of the over-all institutional program.

THE above are some of the common types of patients with whom the prison psychiatrist must work. There are many others. We have seen that in the modern penal system adequate procedures have been established to transfer the seriously mentally ill to mental hospitals for treatment, but these facilities are never quite adequate to satisfy the prison psychiatrist. The receiving institutions are always overcrowded and he must carefully screen his cases to make certain that he sends only those who are most in need, too often those who are the worst administrative problems. He feels the need for psychiatric institutions where he can send his borderline cases for more definitive care than he is able to give, the severe neurotics, the borderline psychotics, the epileptics, the mental defectives and the severe personality disorders; an institution which will receive such patients for treatment without the necessity of a formal certification of incompetency as a prerequisite; a place oriented to psychiatric diagnosis and treatment; for it seems unlikely that, even with a broadening of the legal definition of criminal responsibility, any sizable proportion of such offenders will in the forseeable future be screened out in the courts and sent to mental hospitals.

I am inclined to believe that the best avenue of approach to better treatment for the abnormal offender is through the expansion of psychiatric services in the correctional system rather than through changing concepts of criminal responsibility. Certainly it must be aknowledged that a high percentage of repetitive offenders are mentally ill in the psychiatric sense, if not in the social or legal sense. Perhaps one of the major contributions of psychiatry to criminology to date has been the recognition that many of the types described above are incapable of responding to the rehabilitative program of the modern penal institution, that they require something more, that they need to be segregated into special institutions or programs and at least exposed to a more intense psychiatric program.

HANDLING STRESS

THROUGH IDENTIFICATION

Charles L. Nord, M.D.

Chief Medical Officer, Federal Correctional Institution, Ashland, Ky.

"YOU mean, Doc, that if you could let me go and I'd give you a million dollars or so of two million I had stashed away when I got out, you wouldn't do it? I'll bet you wouldn't!" The 21-year-old forger, speaking in group therapy session, was saying that everyone can be bought. His fellow indeterminate-sentence servers agreed with him. They felt sure that, when severely tested, all people decide by their desires rather than realistically, bearing consequences in mind.

All of the 500 youthful offenders at Ashland have been tried severely. They have lacked parental guidance and have often known other hardships. Sometimes death or divorce destroyed the home. Frequently, their parents have been so handicapped by their own concerns, fears and inability to adjust that they have been unable to help their children mature.

Ted's parents, for example, proved themselves unable to handle their parental responsibilities. His father sought support in alcohol and in extra-marital affairs. Ted's schoolmates labeled him the drunkard's son. His mother found and shot the other woman. Ted now found himself ridiculed even more. He attempted to get his fellows to give him serious recognition through fighting when he felt that he was challenged. This response gained him expulsion from school.

Like Ted, each of the fellows has his individual background and experiences. They have in common the reactions of distrust, pretended indifference and defensive anger. They also wish to get away and escape from unpleasantness.

Putting yourself in their most difficult situations, you sympathize and see that they would wish to realize their desire to avoid the things

that they must face. However, when they can call forth sympathy on demand, they tend to hope that they can go on living on someone else's resources. They can be helped only when they can be reached by a program that makes them conscious of their capabilities and aware that they must meet their day-to-day responsibilities.

The youths are at Ashland because they mishandled tests and ignored their responsibilities in a self-defeating manner that was not appropriate to their abilities and to their situation. They decided that they would have to settle for a quick and immediate solution of their problems. Such a solution involves translating a dream into action. The youth without funds helps himself to someone else's money; the one without a car acquires one.

Another forger we treated, while working and making money, gave way to his decision that he needed a large sum of money immediately. He told himself that he had to take the money he needed rather than earn it, and that his parents could not be counted upon to help.

As he came to look at his past experiences, he recognized a tendency to evade issues and avoid reckonings. He got along precariously with his parents by distorting the truth and lying. In this way he cut himself off from support. Then he found that his impulses and his immediate requirements were so strong that they determined his actions. The same sort of thinking occurs in the usual car thief's insistence that, because he had no other resources, he had to take the car for transportation, or for prestige, or for revenue.

THE student of human development recognizes the struggle to overcome self-destructive dependent strivings and to mature throughout these youthful offenders' concepts and activities. The rare offender senses that in this struggle he needs help; that his faulty judgment and lack of perspective show his need for understanding, care, control and guidance. The usual committed youth, however, asserts that he prefers destruction and death to any help or concern. He says that, left to his own devices, he would have all the help he needs. He shares a 20-year-old dopester's insistence that he can handle his affairs as long as people do not meddle with his supply, with the things he needs. He expects to bend these things to his exclusive use, to control his environment through his demands and imperative need. He shows concern only for those people he hopes to use. He cannot admit failures, but must explain rather that these people have failed him. He can relate only

through identification, through wanting to take something he sees that another person possesses. The ultimate self-defeating nature of these activities serves the same end. He says that, if he is destitute and without resources, he must receive recognition and response.

The offender looks for immediate results. He has no ability to wait, since he loses confidence if there are delays or difficulties. The present alone makes a difference. He will accept certain and prolonged punishment in exchange for brief ownership of something, or of some experience he desires.

The need to be entirely right, and to prove this with events, makes him rigid, inflexible and unable to profit from his experiences. Any other point of view seems false to him. He argues that he must continue as he has proceeded. Criticism seems an attack upon his essential make-up. When argument fails, he prepares himself for a finish fight, since he feels that his critics have attacked him and have left him no choice.

Insisting that he is always right on every subject, he unavoidably sets up failures from which corrective experiences can come. As stated before, few fellows will admit participating in any choice that would place them at Ashland. Yet they manufacture a situation that will stop them, although they say that they could not stop or arrest themselves.

In the institution, a similar lack of insight characterizes the established traditions of the prisoner. The fellows all insist, for example, that an escapee is really trying to get away, even though the inevitable result is that he will remain in confinement for a longer period.

Most of the fellows make changes in their points of view and they find themselves growing up so that they can identify with the staff and reach goals set for them. All of them balk at accepting guidance and advice, so they are asigned goals as chances to guide and advise themselves through the results they achieve. The institution offers a variety of graded living, privilege, work, training and educational opportunities. Some participation is mandatory so that they can experience fairly accurately the sort of life they actually earn. They can also see the sort of things held to be of value by the staff and that the staff cares about them and their progress, probably more than they do.

The fellows watch each other's upward and downward progress to see how realistic and how effective the staff can be in its intention to help. They find that the staff realistically provides for the problems they will have in accepting changes in their way of life. Group dis-

cussion programs, group and individual psychotherapy, counseling sessions, religious activities have the job of making the offender take an active part in his rehabilitation by making him aware of his talents and his worth. By taking advantage of these opportunities, the offender can straighten out his objections or offer contributions to the program and the values it emphasizes.

THERE are limits to the immediate effectiveness of the program. The staff's skill in stimulating motivation, the resources of the institution, the offender's ability to respond are all limited. Sometimes everyone agrees that a particular offender cannot be induced to make constructive use of the opportunities that the institution can provide. He has to be recommended for transfer then to show him and others that anyone can succeed in bringing about his own isolation.

The lack of judgment that results in such repeated self-destructive activity can be seen in several of the disturbed youths. As a rule, such youths, even if diagnosed as psychotic, remain in the general work, living, recreational and educational program.

In the case of a 21-year-old car thief, these and special measures proved to be inadequate. He usually started out well on an assignment, so that he earned and received responsibility. At about that point, he showed his need for continued daily concern by attempting to escape, by stealing something or by openly breaking some clear and long-established regulation. (This pattern described his childhood, during which he embarrassed and infuriated his father, a public official, after giving his parents reason to hope that he was more responsible. He behaved in the same way in his marriage and during his brief service experience. After a good start, he would begin to fail. Each time he would confess his failures and then expect to receive another chance made up of conditions he dictated. His new chances benefitted him little, since he recognized only his own point of view and therefore could not use these chances to progress beyond his same infantile stage of development.) Through the time of his transfer, he remained dependent upon the dramatic and forceful support found in the criticism and concern that he forced others to supply.

Everyone who worked with this youth looked for more immediate returns from their investment of time, concern and effort. When he was transferred in the attempt to further his own growth, the staff studied his case to discover why he had not been convinced of his

need and ability to grow up. We found that he defined himself by the reactions of other people toward him. He needed obvious and impressive reactions to convince him that he controlled the situation and that it centered upon him. He excluded himself from any other way of living, even after he was told and shown that he had the capacity to make himself a responsible and successful adult.

The Medical Department contributed additional data to explain his conviction that he knew better than anyone else and thus knew his fears to be justified. These fears took the form of chronic genitourinary complaints, which kept him from sports, kept alive his ambivalence toward sterilization and showed his dissatisfaction with being a male. These inner conflicts perpetuated his distrustful attitude and made him unreachable, except when he could seize the opportunity to absorb and incorporate something he desired from his environment. He remained unaware, in an effective sense, of any experience or influence that indicated that he could or should change his way of life.

Freed by such a worked-out understanding from an over-concern toward these temporary failures, the staff directs attention to improving techniques with the fellows who can respond. In training sessions, discussions disclose that the youths suffer from their childlike inability to measure up to realistic demands. Means of employing ingenuity and invention are laid out to lead the youths from their non-grown-up withdrawal and defensive anger to participation in the expenditure of constructive effort.

WHEN this effort enables the youths to produce, progress occurs. This effort must overcome a variety of handicaps. Some of the youths have handicaps of infantile concepts, of inadequate intelligence, or of organic brain disorder with weakness of impulse control to account for the habit of acting as if their wishes defined a valid course of action. In other cases the handicaps that the youth *believes* he sees in his make-up make him act as if he could not meet responsibilities. The secondary gains of a hoped-for control over their situation also influence the youths to try to force someone to care for them.

The study of the problems and approaches to rehabilitation became of prime importance when in January, 1954, the Attorney General designated Ashland as the Youth Corrections Institution. At the present time 80% of the inmates fall under the Youth Corrections Act and most of the rest are under Federal Juvenile Delinquency Act

commitments. All these youths, aged 15-16 to 22, must convince the Youth Division and Parole Board that they have grown up enough so that they can be expected to live and work successfully outside of the protected situation of an institution.

The institution and the Youth Division cooperate, but work independently, the Division having the sole right of release of the committed youth. Everyone at Ashland realizes that an agency, not an integral part of the institution, will decide whether or not an adequate job of preparing the youth for community living has been accomplished.

In this set-up the need to convince a third party dramatizes the fact that the staff and the youths are partners in a common job. This discovery of common ground facilitates useful identification and helps the youths and the staff to see that each one's advantage depends upon accomplishing an adequate job of rehabilitation. Each comes to recognize that the job of rehabilitation, of arranging and bringing about the process of maturation, calls for hard, consistent effort directed toward an uncertain outcome. In this situation the youths observe the staff at work under constant stress and demand. They see in these models that problems and stresses call for hard and thoughtful application with flexibility and the ability to keep going in spite of disappointments. They learn that skills, education and personality assets can be regarded as useful only when these are constructively directed toward achieving growth-promoting goals.

Learning to produce, learning to work helps the boy to accept himself and others. A 19-year-old parole violator and car thief had misused his opportunities and hazarded his welfare ever since he convinced himself that his parents preferred his younger sister. At the institution he continued to defeat himself through attempting to escape and through disregarding rules and making suicidal gestures. In his discouragement he excluded himself and added excess weight as he maintained his pattern of seeking solace in sympathy and in food. Eventually the efforts expended convinced him that the staff would help him with controls if need be, but preferably with a greater variety of opportunities. He earned promotion to trade training, developed skills and found himself capable of re-evaluating his mode of living. He now speaks of the kindness of others and sees that, as he found it possible to accept himself, he could realize that others found him a worthwhile person capable of learning and of progressing through his experiences and mistakes.

This youth, like the rest of the fellows, learned to face realistic

situations. He complained initially about discomforts and annoyances; all of the fellows do. They frequently tell much about their attitudes and their approaches to problems through these complaints. Usually they insist that an evasion or an elimination of discomforts or strains alone will handle their complaints. The staff recognizes their desires and understands them, but the staff knows that they must learn to handle difficulties and stresses. For this reason the fellows find that they must use help and learn about themselves as they meet difficulties, rather than give in to their natural desire to eliminate and avoid problem situations. As Whitehorn says in the April 19, 1956, *Journal of the American Psychiatric Association,* "Stress is a feature of all meaningful living and . . . emotional health is developed and maintained, not by avoiding stress, but by cultivating well-integrated effort in the advancement of one's purposes."

WHEN youths know that they must measure up to challenges and to difficult opportunities, they grow through the implied expectation that they can do well. This realistic expression of faith in them makes them capable of looking to their co-workers on the staff and of accepting guidance. While working with these men they find through experience that difficult things can be done through effort, through willingness to change, through investigation and through focusing on producing rather than upon competition for prestige or interpersonal preference.

Some of the most eager and most productive of the youths have proved that they have not progressed to responsible living through this program. They were youths who decided that they could make their institutional life more pleasant and rewarding by appearing to cooperate. They indulged in no open rebellion or conflict.

In the process of "playing it cool' while recognizing loyalty and attachment only to themselves, they made themselves fit only for a dependent adjustment and unable to get along in competition on their own. Members of this group have returned to the institution after failing in the community. The errors that have been made are now being examined and work is progressing to find means of dealing with these problems. (Possibly this group and the homosexual group find real change difficult because their inadequate adjustment rewards them with immediate pleasures.)

Whether Ashland will succeed remains a question and a challenge. Preliminary results of slightly more than 10% failures on

parole from the program seem encouraging, but the staff has no feeling of complacency. The youths learn that they must keep themselves alert, teachable, observant and determined to work constructively through each problem that comes up, according to sensible and realistic decisions. They learn not to think of themselves as having arrived and able to rest upon their achievements. This same restless searching and changing attitude characterizes the staff. If a youth released does well, everyone rejoices in his happiness and gain; if he fails, his mistakes become the opportunity for everyone to learn and improve. Neither outcome really surprises. In working with these youths, the members of the staff come to examine their own personal adjustment. Those who study themselves know that they or anyone possess security only as long as, in their available circumstances, they can put forth the effort required to make themselves secure.

SUMMARY OF PAPER

The staff at the Ashland, Kentucky, Federal Correctional Institution found a challenge and an opportunity in the fact that a cooperating, yet separate agency, the Youth Division, would decide the release date of the youths it was preparing for a return to community living. The youths and the staff found that they had to work together to accomplish changes in living patterns in order to secure any favorable parole consideration.

In working together, the staff and the youths learned about each other. The staff noted that the usual youthful offender, unless controlled, acts in an infantile self-destructive manner and that he lacks insight into his attempts to satisfy dependent needs. The offender found that the staff was a realistic authority group, sympathetic to his problems, yet determined to help to the extent of its ability whatever the response of the offender.

The youths must take part but they are provided with opportunities to talk over their misgivings about putting forth effort.

The opportunities for working at a common task and for observation facilitate the process of identification of the youths with the staff. Through this process, the youths discover useful ways of living, their ability to produce, and the rewards of constructive effort.

The Medical Department interprets, clarifies and treats so that functioning can be improved through the keener understanding which makes relationships constructive.

Preliminary results are encouraging enough to make a continuation of this study and effort seem worthwhile.

PSYCHIATRIC PROGRAM OF THE CALIFORNIA MEDICAL FACILITY

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THE World Health Organization considers general good health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This is a sound definition applicable to all walks of life which has received widespread acceptance. It means that the health of one who persistently overeats may be below par due to increased weight even though there is an absence of clinical disease, or, another, subjected to prolonged strife and stress, does not have sound emotional health even though mental illness is absent. Views regarding the mental health of prisoners are divergent. However, it is generally conceded that the lives of most offenders are burdened with suspicion and hostility and more burdens are added when men are convicted and exposed to the prolonged restrictions of confinement. Within the meaning of the definition it is evident that the state of emotional health among prisoners is usually low even though disease may be absent and even though such impairment may not be severe enough to justify a psychiatric label. In addition, there is the ever-present relatively large number of ill-defined minor disorders and the lesser number of obvious psychoses. These problems of mental health and psychopathology, so prevalent in the prison setting, together with crime, the common symptom, require psychiatric attention if favorable progress is to be made in correctional work.

SCOPE OF PSYCHIATRIC SERVICES

THE type and scope of psychiatric services provided for offenders in California are partly reflected in the laws of the state and rules and regulations of the Department of Corrections. There has been a trend toward more and better services since 1944, when the Legisla-

ture enacted the Prison Reorganization Act, creating the new Department of Corrections and providing for an expansion and improvement program.

Reception guidance centers, which serve as evaluation, orientation and prescribing units for newly admitted offenders, have been established at San Quentin in the northern part and at Chino in the southern part of the state. A third, more recently established at Tracy, serves younger male offenders. The staff of a reception guidance center includes qualified psychiatrists, psychologists, sociologists and other professional workers. An important part of the work consists of the pychological and psychiatric examinations and recommendations. In the event of need of further psychiatric observation and treatment, the subject is usually placed in an institution that has a strong psychiatric staff such as San Quentin, or more recently, the California Medical Facility. Two smiliar centers are administered by the Department of the Youth Authority for adolescents. The staff of the institution for women process their own cases.

The Penal Code requires a psychiatric examination of those convicted of committing lewd and lascivious crimes on children under 14 years of age. Such person shall not have his sentence suspended until the court obtains a report from a reputable psychiatrist as to the mental condition of the offender, and such person shall not be paroled from prison until a report is received from the prison psychiatrist setting forth the prisoner's mental condition. The California State Law also provides that the Director of Mental Hygiene, with the approval of the Director of Corrections and the Director of Finance, may provide on the grounds of a state institution or in institutions under the jurisdiction of the Director of Corrections or Department of Mental Hygiene, one or more institutional units to be used for the custodial care and treatment of sexual psychopaths. In accordance with this provision, certain correctional institutions where psychiatric services are available are designated as units for the care and treatment of sexual psychopaths and selected cases are transferred from some of the state hospitals or the courts to such units, particularly to the California Medical Facility. Furthermore, provisions also exist for the transfer of certain psychotic or insane prisoners from correctional institutions to state hospitals and psychopathic delinquents from state hospitals to prisons. There has thus been an increasing trend toward an interchange of psychiatric services between California correctional institutions and certain other state agencies.

An important requirement of the Adult Authority (the paroling authority) is that a complete psychiatric report, including diagnosis and prognosis, shall be submitted at the time certain categories of inmates make their annual calendar appearance before the board. Furthermore, the chief medical officer or the psychiatrist shall also be present at such hearings. These categories include all life-term prisoners, all sex offenders, all arsonists, all inmates committed for murder and aggravated assaults, all inmates showing an historical pattern of sex deviation, arson or aggravated assaults regardless of offense or offenses for which committed, all cases recommended for inclusion by the clinical staff of the Reception Guidance Center or by the institutional psychiatric department, all men returned from facilities operated by the Department of Mental Hygiene or such others as may be added thereon by the Adult Authority.

A final example of legal provisions for the psychiatric care of offenders, and more in keeping with the subject at hand, is the establishment of the California Medical Facility. During the early planning period of the department the need of a special institution for the care of the physically and mentally handicapped, particularly the latter, seemed apparent. This need was confirmed by a special survey resulting in legislative approval for a special institution designated as the California Medical Facility and acquisition of a site of some 900 acres for it near Vacaville in Solano County. Because of critical overcrowding, the 1949 session of the Legislature authorized the establishment of the Medical Facility in temporary quarters. The former Naval Disciplinary Barracks, Terminal Island, San Pedro, was leased for this purpose and a limited program was developed, July 1, 1950. The program gradually expanded and continued unabated until April, 1955, when it became possible to move to the new permanent facility at Vacaville.

THE current normal capacity of 1,350 beds will be increased to a total of 1,950 beds during the mid part of 1957 when construction work still under way is completed. The additional space will be occupied by the Northern Reception Guidance Center, which will be moved from San Quentin to Vacaville at that time. The staff organization is patterned after other institutions under the jurisdiction of the Department of Corrections. The line of organization consists of the head of the institution or superintendent and four major divisions. A business manager is in charge of the business administration, which

embraces financial and fiscal affairs, culinary section, laundry and maintenance activities. An associate superintendent, custody, is in immediate charge of all security features of the institution. Another associate superintendent supervises the educational, recreational and religious activities, classification, social service work and activities related to the training of patients. The Director of Clinical Services has immediate charge of the treatment program, embracing all psychiatric, medical, surgical, psychological, nursing and diagnostic activities. Because of the purpose of the institution, emphasis is, of course, slanted toward the clinical staff and program. The staff includes more than 300 members and all are under the Civil Service System and receive orientation and instruction in the in-service training program.

The law is sufficiently broad to permit the admission of any adult male inmate who is so disabled as to require special study, treatment and care. In this respect the Medical Facility may be used as a general hospital, but the early intent of the Department of Corrections and the Legislature was to give priority to those in need of psychiatric studies and treatment, particularly those troubled with borderline and ill-defined defects. Except for the admission of those afflicted with active tuberculosis, the intent and policy regarding priority for neuropsychiatric cases has been followed. As a consequence, the normal or official capacity of 1,350 beds are occupied by approximately 175 tuberculous patients and 75 non-patient workers, while the remainder are occupied by patients afflicted with mental illnesses and deviations. The group of more than 1,000 mental patients embraces many and varied disabilities ranging from malignant psychoses to minor emotional deviations, particularly the latter. A common characteristic, of course, is the history of crime, with offenses involving property, sex, forgery, homicide and narcotics predominating in the order named. For all intents and purposes the Medical Facility thus serves as a hospital for mentally abnormal offenders.

TYPES OF MENTAL PATIENTS

AT the Medical Facility the common striking symptoms of major mental illness are the major criteria for the classification of mentally ill patients as psychotic. In other words, such patients would usually be committed to a state hospital if granted a court hearing in the outside community. Those thus classified as psychotic number approximately 150 and include the majority of all afflicted with major

mental illnesses in the prison system or approximately 1% of the total general population of almost 15,000 men. Schizophrenia is the leading disability, embracing approximately 50% of the cases. Psychoses associated with abnormal personalities are also encountered frequently, while psychoses attributed to arteriosclerosis and other organic changes occur less often than in other hospitals.

The most common symptoms are delusions of a persecutory nature, manifested by approximately 80% of the group. There is also a history of auditory hallucinations occurring in about 50% of the acute episodes, often characterized by voices referring to them as "stoolpigeons" or other derogatory terms common to prison life. Feelings of depression, apprehension and apathy predominate over euphoria. Self-inflicted injuries, destructive and aggressive acts are common. The symptoms are thus similar to those observed elsewhere, but colored to a considerable extent by past experiences and difficulties. At least 30% of such patients manifest gross symptoms of major mental diseases during the first year of confinement and historical data often support the presumption that many were mentally ill before the offense. The majority of cases labeled as psychotic after confinement for one year or more usually manifest paranoid trends as the predominating symptoms. In the event of need for further care at the time of expiration of sentence, arrangements are made for commitment to a state mental hospital under the jurisdiction of the Department of Mental Hygiene.

In contrast to those who are psychotic, the borderline group, that is to say those falling within the intermediate zone between the normal and the psychotic, is a large and important one. The boundaries of this zone are not well defined or distinct because those within it are afflicted with diverse types of disorders, the true nature of many of them is still poorly understood and methods of measuring the degree of disability are inexact. Some are so vague, changing and ill-defined as to defy precise classification. Nevertheless, administrative considerations as well as the interests of proper therapy call for a reasonable degree of distinction between behavior due to mental disability, on the one hand, and plain deliberate delinquency, on the other. Most crimes may be construed either as symptomatology of mental abnormality or as simple malicious conduct, depending on the nature of the motivating forces. The distinction seems obvious between the man who burns his barn with a view to collecting insurance and the firesetter who, without profit or regard for life, repeatedly burns buildings

because of an uncontrollabe urge. The first is an act of wickedness and greed. It may induce or be associated with poor emotional health, but it is rational and understandable and free from clinical disease. The second is a mark of something strange and dangerous and pathological. Both may be convicted of arson and sent to prison. After evaluation in the Reception Guidance Center, the first would be sent to one of the regular institutions and the second to the Medical Facility.

IT is now quite generally conceded that a person should not be given a psychiatric label just because he has participated in a single homosexual act, even though convicted and sentenced to prison. Additional single factors, or combination of factors, such as repetition, obsessive thinking and compulsive acting out, must be elicited before a finding of deviation can be fully justified. This is usually not too difficult; even the inmate population quickly detects the real "queers." Neither should an offender be considered abnormal or disabled just because of one or several shots of morphine. Psychiatric certification of addiction should be supported by evidence indicating that the victim on some occasion actually passed from the phase of voluntary, irregular and experimental use of the drug into the trap of bondage, characterized by physiological dependence, increased tolerance and loss of self-control with respect to use of the drug to such an extent that the major business of life thereafter becomes a continuous effort and obsession to keep open the channel of supply. In other words, there is a point somewhere along the course of tampering with narcotic drugs that is a danger point because it is not clearly marked and the victim who goes beyond it becomes a sick person indeed. Furthermore, even though the physiological dependence and tolerance are lost through enforced abstinence, there remains a submerged permanent psychic awareness of the strange power of the drug, and this awareness is prone to rise to the surface in the event of discomfort or distress. This constitutes a real and permanent danger in regard to relapse unless defenses are developed through long treatment and training and thereafter observed through constant practice.

More numerous and more difficult are the relatively young, perverse and aggressive recidivists, who crave excitement and frequently find themselves in prison for offenses most frequently involving property. The majority of this group make at least a superficial adjustment to routine institutional programs. However, regardless of

the availability of opportunities for self-improvement, there are always some, and the California System has its share, who are unable or unwilling to adjust. They are free from significant physical or neurological defects. In fact, they are usually above average in physique. During interviews some appear to be intelligent, pleasant and at ease. Others are surly, belligerent and dangerous. Through their own folly all are intermittently in trouble and find themselves in punitive and segregation units for long periods of time. Regardless of segregation or other approach, they are unresponsive, obstructive and chafe under restrictions. It seems to be fairly well agreed that these troublesome cases are not bothered with guilt feelings or remorse and suffer but little from anxiety, because frustration and tension are usually dissipated in outbursts of violence against property, others or themselves. Psychiatrists have believed for more than 100 years that such offenders are abnormal and at different times many diagnoses, ranging from moral imbeciles to constitutional psychopaths, have been used that in the aggregate exceed more than 100 different terms.

THERE are a few who are inadequate and shy and seclusive. Others exhibit so much overlapping and so many changes in symptoms that a clear-cut classification becomes impossible. Regardless of the predominating delinquency pattern, many harbor inner discomforts and hostility toward authority of such degree that it is often projected in a way as to suggest a diffuse paranoid state, sometimes bordering on schizophrenia.

Excluding the psychotics, epileptics, mental defectives and those afflicted with structural brain damage, a conservative estimate indicates that some 15% of the population of the California Prison System, or some 2,000 men patients, exhibit defective thinking, feeling and conduct of such a nature and degree as to be classified as mentally abnormal. The characteristics of some have been briefly described. A portion of them, approximately half, have been selected as potentially responsive to treatment and are presently at the Medical Facility. Partly for psychiatric reasons and partly for administrative purposes, the quota established for the Medical Facility embraces roughly some 150 homosexuals, 250 sex deviates other than homosexuals, 100 drug addicts, 100 obsessive-compulsive types, 200 unknown types for evaluation and treatment, and 250 abnormal personalities and mixed categories of one type or another; a total of about 1,950 ill-defined and borderline patients. This classification does not, of course, necessarily

reflect the true condition. It reflects rather the predominating symptoms of deep-seated and long-standing pathology. Such symptoms, when based on the offense of record, do not always effect the dominating behavior pattern of the individual. For example, a patient convicted and committed as a burglar may actually be a confirmed narcotic drug addict and the burglary may be only incidental to the addiction. In such an event he would be classified under drug addiction, the predominating trait or symptom. Sometimes the records of a patient include different diagnoses by different qualified psychiatrists at different times. Even the same psychiatrist may record changes in his conclusions at different times, a change he may be unaware of himself. This, of course, is not due to poor professional work but rather to the absence of precise standards and the protean symptoms manifested under different situations at different times by many patients in these categories.

PSYCHIATRIC TREATMENT

PRISONERS as a group are kindly disposed toward the physician who repairs their remedial defects. They are grateful for medical and surgical relief and sympathetic toward others who are sick, as reflected by willingness to donate blood and otherwise contribute to the welfare of others. Some have even endangered their health by participating in research projects related to communicable diseases. Sanitary and preventive health measures are also accepted and usually observed according to prevailing standards and the modern correctional institution is as safe as any community as far as general health is concerned. The physician and his staff thus have fixed, satisfying and continuing duties with respect to the care of the ill and the health of the prison community. But all of this work, essential though it be, has assumed much of the status of a routine maintenance operation, largely because it has no specific effect on criminal tendencies.

In contrast, prisoners are often resentful toward the psychiatrist who attempts to evaluate and correct their mental disabilities. Not long ago this amounted to outright rejection and ridicule, but fortunately a steady trend in the opposite direction is now evident. The favorable results from psychiatric treatment are seldom so prompt or spectacular as those resulting from surgical correction of a disfiguring and disabling defect or the cure of a critical illness. The great medical advances, such as the amazing properties of the antibiotics in combating infectious diseases, do not include corresponding discoveries in

the treatment of mental illnesses. Furthermore, health codes, such as those that provide standard, fixed and specific techniques for the pasteurization of milk and other protective sanitary measures, are not yet available for safeguarding mental health.

Despite the lag, psychiatry has accomplished more than is generally believed. Advances in the classification of mental disabilities, the development in diagnostic appliances and tests, the improvement in old and the employment of effective new therapeutic methods have been substantial during recent years. In fact, contributions to the classification and treatment of offenders have been so helpful that dedicated workers in correctional fields consider the need of psychiatric services, particularly treatment, more essential than all other medical and technical services combined. In the California correctional system the former predominating domiciliary and custodial concept has largely given way to the therapeutic approach and this is the principal justification for the existence of the Medical Facility. The advent of individual psychoanalysis, shock therapy, psychodrama, lobotomies and the lesser emphasized therapies have each in turn created increasing enthusiasm and hope. Although helpful, and still used in selected cases, each type has its definite limitations in institutional work. At the moment the level of interest has reached an all-time high because of the practical advantages and effectiveness of the more recently developed tranquilizing drugs and group psychotherapy.

THE clinical program of the Medical Facility has included most recognized and standard therapies. The new tranquilizing drugs are used extensively, but largely limited to the group of patients, mostly psychotics, who are disturbed to such an extent as to require confinement in the maximum-security section. The noise, violence and destruction formerly characteristic of this section have diminished greatly. As a consequence, too, electro-shock therapy is now very seldom administered. Individual psychotherapy is practiced by members of the clinical staff as time and the exigencies of situation permit, but this does not include orthodox individual psychoanalysis. When the medical and psychiatric program was organized at the temporary facility in 1950, group psychotherapy, used elsewhere with both good and indifferent results, was selected as the most practical therapeutic approach, particularly for the large numbers of borderline mental cases. Exposure to prolonged adverse emotional and social forces appeared to be the common and major etiological factor and the

group method seemed to offer the most feasible and best-known means of dealing with their problems. At no time has experience with the group psychotherapy program indicated that it should be dropped or curtailed; on the contrary, progress has been so encouraging as to warrant expansion and this has been done.

There are currently eleven full-time therapists, two of whom have an educational background in psychiatry, four in medicine, two in clinical psychology and the remaining three in sociology and psychology. All are trained and serve under the direction of the Clinical Director, who exercises immediate supervision over the program. Each therapist carries a load of about 100 patients, which amounts to a total of more than 1,000 patients under treatment at present. There is an average of about ten patients assigned to each group and each group convenes twice weekly for a period of one hour per session. There are special groups, comprised of tuberculous patients, selected psychotics, pre-parolees and adolescents. Members of a few groups are specially selected on the basis of narcotic drug addiction, particularly those whose crimes have been incidental to addiction. One and occasionally more groups are limited to Mexicans, who have trouble in understanding and expressing themselves in English, under the leadership of a therapist who speaks Spanish fluently. Otherwise, no special effort is made toward achieving homogeneity in composition of the groups.

The therapist assumes an unobtrusive yet dominant role. A permissive atmosphere prevails and members are encouraged to divulge and work through their feelings and problems. This is difficult and sometimes impossible for new patients. Some are quiet and cooperative but attend the sessions for several weeks before participating in the discussion. Others request private interviews, want individual attention, submit requests to the superintendent for transfer, attempt to manipulate the therapist into securing special privileges, or otherwise divert movement from the real goal. At times verbal resentment and even hostility alternating with flattery are expressed individually or collectively in further attempts to turn the session aside from its proper course. The understanding therapist detects the usual motivating factors of anxiety and hostility, but at times he cannot avoid some discomfort from the heckling and manifestations of rejection. He stands firm, resists demands for private consideration and makes it clear that dealings with an individual member must take place during the session and what happens must be known to the others. Further,

that the objective is to help the individual to help himself and to do so the individual must do most of the work, which admittedly may involve some distress and sometimes pain.

Despite distress during the beginning, in some cases lasting for several weeks or even months, the group finally settles down to the work at hand. Then the amount of material, previously submerged, that comes to the surface is often amazing. All participate in interpretations and sooner or later there develops group unity, respect for the therapist and inner shift of negative to positive feelings, all of which are associated with relief of tension. This phenomenon of multiple transference, the hallmark of depth psychiatry, involves the emotions rather than the intellect; the heart rather than the head. Favorable progress is evident when a member begins to experience relative psychic ease, a decrease in psychosomatic symptoms and a sense of belonging. Improvement is certain when officers, parole authorities and others express surprise and gratification because of a change in attitude and conduct from hostility to friendliness, from obstruction to cooperation and from contempt to respect for authority. This is the type of definite change that has occurred frequently enough to justify the conclusion that the group approach is the most effective approach today.

ADJUNCTIVE THERAPIES

THE group psychotherapy program involves long-term treatment, which cannot be carried out in an isolated or semi-detached fashion from other activities. The sessions do not exceed two hours weekly and the manner in which the patient progresses during the many hours of absence from the sessions often amounts to a test of the effectiveness of the treatment. It affords an opportunity for the patient to apply what he has experienced and learned. His reactions and progress during this period may also serve as a test of the general institutional program. The total program, that is, all services and activities, are geared to the clinical efforts. In other words, in addition to the technical psychiatric work, there is a continuous supporting program in which each member of the staff participates to some degree, according to the nature of his duties. These activities not only help to sustain motivation for further treatment but often produce specific benefits by themselves.

Following admission some patients register surprise when they

find they are expected to work. Most of them understand they have come to the Medical Facility for psychiatric treatment, but some say they do not need it. In addition, some assume that the treatment consists of remedies and measures to be administered without exertion on their part and a hospital situation should assure a life of ease. This assumption is wrong. It is wrong because exercise or work is an essential therapeutic factor in the restoration of strength and function to many impaired physical structures and mental capacities.

The bodily structures and functions of most of the patients are good and some excel in gymnastics. Their muscles are strong and efficient because of constant use. In contrast with the prevailing good physical health, all have impaired mental capacity of one type or another, particularly in social relationships and ethics. These impairments, like weak muscles, are largely due to atrophy from prolonged disuse and they, too, must be stimulated and put to daily use if function is to be restored. The treatment of such deficiencies during the group sessions requires special efforts on the part of the individual patient. The disclosure of ugly personal experiences and feelings and the evaluation of problems of fellow members is a hard and unpleasant task. The awakened capacities are put to constant use on the work assignment, in the schoolroom, on the recreational field and elsewhere. This is all difficult work at first, but with sincerity of purpose and diligence it gradually becomes easier, more satisfying and finally new attitudes and patterns of behavior become established.

Just as members of the small psychotherapy groups gradually develop into cohesive units, efforts are made to promote similar feelings and unity in the work gangs, educational classes and other large groups with the aim of developing a wholesome attitude toward the staff and a sense of belonging to the institutional community as a whole. The psychological need and value of group identification combined with adequate leadership have recently been emphasized in military practice. The principle is also being effectively and extensively applied in the California regular correctional institutions through the medium of group counseling, with officers and supervisors serving as leaders, resulting in remarkable improvement in feelings and attitudes of both inmates and officers.[1] Emphasis, through in-service training, staff meetings, consultations and otherwise, is also placed on the continuous need at the Medical Facility for respect and under-

1 The Prison as a Therapeutic Community, Norman Fenton, Federal Probation, Vol. XX, No. 2, June 1956.

standing between staff members of different services. For example, to achieve maximum effectiveness in treatment and control, a high degree of reciprocal support and aid must exist between the clinical and custodial services. This can be attained only by the development of mutual kindly feelings and confidence.

A GENERAL deficiency among the patients is the utter lack of worthwhile interests. Constant vigilance is exercised by members of the classification committee and others to detect each spark of interest and build it into a flame of enthusiasm whenever possible to do so. Men vary greatly in this respect, so it is fortunate that opportunities are available for academic education, vocational training, religious, library and other services. Each man, according to his ability, is expected to assist, at least part time, in the maintenance of the institution, which is necessarily self-contained, with work assignments ranging from ordinary labor to rather complex technical duties. It is always a great reward to the supervisor to observe the man who suddenly begins to manifest continuity of effort, serious-mindedness and a degree of maturity because of enthusiasm over a given task.

A former patient, labeled at one time as a psychopathic personality and narcotic drug addict, became excited over fine arts in the Occupational Therapy Department. His aggressive demanding traits subsided and he began to produce paintings of amazing quality. He is now outside attending art school, working and at peace with himself and the world. A letter from another, recently released on parole, reveals his progress in part as follows, "The main fight that I have is the fight against loneliness, and from what I am experiencing now I begin to get the idea of why some of the fellows seem to dash back to prison as soon as they can." This suggests that the need of group integration is more easily fulfilled within the institution, but it also indicates a lack of sustaining interests. After all, the more essential part of each person's life is lived as a single individual and, regardless of the benefits of group identification, it is also necessary to be able to maintain personal independence.

In addition to the technical therapeutic procedures peculiar to psychiatry, there are thus other methods of helping men with their emotional problems. Many of them are old and varied, ranging from religion to work, and in the institutional setting there is overlapping and need of correlation and balance to such an extent as to require close administrative attention. They do not serve as a substitute for the

psychiatrist in dealing with definite mental illness, but in a rough way at least they have been synthesized into a supportive and preventive mental hygiene program.

The results of the psychiatric program have been encouraging but not so remarkable as to invite any degree of complacency. Experience indicates that success or failure of the program depends on a rather careful administrative balance between the number of those who are reasonably receptive and those who are dangerous and obstructive. Also, certain patients must be given a trial at therapy and sometimes a second test before a decision can be made regarding their suitability for treatment. The adjustment units at Folsom and elsewhere are still harboring aggressive, hostile men. Some of them have been at the Medical Facility, where they proved to be so obstructive and unresponsive it was necessary for them to return to the place from which they came. Others of the same type remain under treatment and are progressing favorably. Changes have occurred in other chronic inadequate cases often enough and marked enough to engender favorable expectancy in regard to the future and also to justify the conclusion that human nature can be changed.

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LONG before Freud, Francis Bacon, a lawyer, said, "Numberless are the ways, and sometimes inscrutable, in which the affections color and affect the understanding"; and "a man's disposition and the secret working of his mind are better discovered when he is in trouble than at other times."

—Benjamin Cardozo

WHAT we ought to fear above all is not the absence of a definition, but being saddled with a false definition. We must avoid the rigidity which precludes inquiry, which shuts out light and insists on concepts that are at odds with things known and acknowledged not only by the medical profession but by all informed men.

—Simon E. Sobeloff

FORENSIC PSYCHIATRY AND THE STATE HOSPITAL SYSTEM

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THIS subject is presented from the point of view of the superintendent of the Atascadero State Hospital, which confines and treats certain offenders, psychotic and non-psychotic, designated for hospitalization rather than imprisonment. My purpose is to suggest principles necessary for the proper selection of these patients as suitable for the mental hospital, whose tradition and development has centered on the care of the psychotic or insane.

In California the Penal Code and Welfare and Institutions Code designate certain psychotic and non-psychotic offenders for care in the hospitals of the Department of Mental Hygiene. Some of these patients are housed in the general hospitals for the mentally ill and others are treated at the Atascadero State Hospital, the department's maximum-security institution. A convict who becomes psychotic in state prison is hospitalized by the Department of Corrections in its hospital at Vacaville until the expiration of his sentence.

Non-psychotic alcoholic and narcotic addicts of both sexes are cared for in the general state hospitals, and the female criminal insane are divided between two of these. The 1,200 Atascadero State Hospital patients are all males, and comprise the criminal insane, the sexual psychopaths, the psychopathic delinquents and certain civilly committed psychotics who would be a security risk in the general state hospital.

The code provides for the commitment of alcoholic addicts to the general mental hospitals for a period up to two years, the actual time of confinement to be at the discretion of the hospital superintendent. The narcotic addicts likewise are limited to two years'

confinement, but must be held at least three months. The law implies that these patients be of good moral character, aside from their addictions.

The criminal insane are divided into the two types: those who are too psychotic to stand trial and those who were mentally irresponsible at the time of the act. The first group is returned to court to continue their trial when they have recovered sufficiently to understand the nature of the charges against them and can cooperate rationally with their attorneys. The second group (those not guilty by reason of insanity), if they are not immediately freed by the court, must be held in the state hospital for one year before the question of their recovery can be raised. After this period they may be declared recovered by the court and freed.

The psychopathic delinquents are minors (in practice nearly always males), not necessarily convicted of an offense, who are committed to the state hospital for an indefinite period. There has been a previous observation period at the hospital, during which the superintendent decides whether the case fits the legal definition, and whether to recommend commitment. The legal criteria are that the non-psychotic minor have a psychopathic personality and be a menace to human safety or property. After a period of treatment the patient may be placed on leave-of-absence by the superintendent, if the committing court does not object. This law is used infrequently, most sane minors being confined and treated in the facilities of the Youth Authority. However, under its provisions we receive certain cases from the Youth Authority, usually those who are emotionally labile to frustration or have a sexual problem. Should a psychopathic delinquent be disruptive and unmanageable in the hospital setting, we may transfer him to a facility of the Department of Corrections. The device for this transfer is the establishment of "institutional units" of the Department of Mental Hygiene for the treatment of psychopathic delinquents in some of the facilities of the Department of Corrections. Such transfers are rarely made, but this device has proved necessary as a safety-valve for the removal of certain cases that would otherwise force us to turn the hospital into a prison.

THE sexual psychopaths are in practice always males and are selected from non-psychotic persons convicted of an offense not invoking the death penalty. After a period of observation at the Atascadero State Hospital to determine whether the patient is a sexual psychopath as

legally defined, he is recommitted by the court (subject to judicial hearing) for an indeterminate period as a sexual psychopath. As interpreted, the legal criteria are that the man suffers a personality disorder producing abnormal sexual desire in a degree and kind to constitute him a public menace. This definition tends to exclude the homosexual (not a menace) and the rapist of the physically mature female (no abnormal sexual desire), but does include typically the child molester. The hospital superintendent's opinion, should it be that the man is not a sexual psychopath, is binding on the court. After the indeterminate case has been treated sufficiently that he is considered to be no longer a menace, the court may grant him probation or may sentence him on the basis of his original conviction. The law also provides for the confinement of certain of these cases in an "institutional unit" of the Department of Mental Hygiene for the treatment of sexual psychopaths in a facility of the Department of Corrections. We use this provision infrequently in cases that prove to be so disruptive or unmanageable as to require prison rather than maximum-security hospital custody.

There is a code section related to the sexual psychopath law that provides for the commitment of so called mentally abnormal sex offenders. These are persons who feel inclined toward committing a sexual offense and desire treatment for their predisposition. The court may commit the patient for a period up to two years, the superintendent having the authority, as with the alcoholic, to discharge him at any time within this period. There can be no criminal charges pending in these cases.

Atascadero houses about 300 criminal insane, 700 sexual psychopaths and about 30 psychopathic delinquents. These male cases occur in this state of 13,000,000 people at the monthly rate of about 10 criminal insane, 40 sexual psychopaths including four mentally abnormal sex offenders, and two psychopathic delinquents. It will be noted that about two-thirds of the patients are non-psychotic.

The justification for treating these non-psychotic offenders in a hospital rather than sentencing them for their offenses are, first, that they suffer a personality disorder, and second, that they are less recidivistic following hospitalization than after imprisonment. Additionally, the prospect of punishment as an instrument of deterrence is irrelevant with sexual psychopaths because, in contrast to other types of offenders (thieves, income tax evaders, speeders, rapists), these patients are motivated by desires that the rest of us do not feel. In other words,

we could repeal the laws making pedophilia or exhibitionism a crime and we would not be confronted with more of these offenses. On the other hand, if we were, for example, to remove the penalty for stealing or statutory rape of the mature female, these offenses would certainly increase. We can handle in the hospital setting offenders motivated by abnormal desire without increasing the incidence of offenses so motivated, but it is debatable whether we could similarly handle offenders whose behavior represents failure to control normal temptation, without increasing these offenses.

GRANTED that the sane offenders selected for hospitalization need mental treatment, the mental hospital is ordinarily a better setting for psychotherapy than the prison, because in the hospital the atmosphere of rejection is absent. In the medical or hospital tradition we accept the patient and treat him for the cause of his misbehavior in order to save him. In the prison tradition, or the tradition of punitive incarceration, we reject the criminal because of his crime. The point is that mental treatment is impossible in an atmosphere of rejection. Psychotherapy depends on patient morale, which in turn depends on our accepting him as a fellow human, worthy of improvement. Traditionally, this spirit is of the hospital rather than the prison.

With certain offenders benefiting more from hospitalization than from imprisonment, we must recognize the danger of adopting rules or procedures that would force us to change the hospital into a prison. To clarify the distinction between these two types of facilities, we should understand that the security measures of a maximum-security mental hospital have evolved from experience with the psychotic or insane. The nature of his illness makes it impossible for a psychotic patient to scheme and plot with another. He is inherently incapable of conspiring or taking part in organized activity. For this reason security measures of a mental hospital are not designed to protect against rioting or hostile group activity. It is to handle this type of behavior that prisons, not mental hospitals, are designed. The custodial procedures and attitudes to protect against rioting partly create the atmosphere of rejection traditional in prisons. In the hospital there is no need for the "cold war" (which is synonymous with mutual rejection) between inmates and guards that is fostered by the threat of rioting and organized activity. The spirit of rejection, with its blight on psychotherapy, is therefore unnecessary in a mental hospital.

All this leads up to the point that if the mental hospital, with

its spirit of acceptance and psychotherapy, has special value for certain non-psychotic offenders with personality disorders, then the hospital must have the power to select its non-psychotic patients. Otherwise we may be legally required to accept and house certain non-psychotic offenders (such as the general criminal psychopaths) who, although in need of mental treatment, would force us, for security reasons, to change the hospital into a prison. The salt will then have lost its savor, so to speak. Our key to understanding this is that psychotic patients do not riot. Any psychotic patient is acceptable in the hospital, but some non-psychotics in need of mental treatment should receive it in prison.

The question now is, do the statutes and code provisions recognize this principle? As a rule, in California they do. The sexual psychopath law is particularly sound in this regard. The superintendent has the power to select the patients suitable for treatment, and should his selection prove wrong, he can always eliminate a patient by returning him to court. The court may then either sentence him on the basis of his original offense or may recommit him as a sexual psychopath for placement in an "institutional unit" in a facility of the Department of Corrections. The basis for this is that the man stands convicted and therefore may be sentenced. It will be noted that he has not been declared criminally irresponsible because of his predisposing personality disorder. The practical value of the sexual psychopath law lies in its provisions that the hospital has the choice of its patients and the court retains the decision on when they return to society. The fact of the conviction allows three possibilities for the subject: hospital, prison or return to society.

ALTHOUGH the psychopathic delinquent law is not as clear as the sexual psychopath law, in that there is no provision for conviction with later possible sentence, the state Attorney General's opinion that "institutional units" for the treatment of psychopathic delinquents are possible in facilities of the Department of Corrections has given the hospital the protection it needs. Otherwise, once having accepted such a case, the superintendent's only alternative would be to recommend his parole, which of course could not be honestly done, the subject being unmanageable in the hospital. As I have said, this transfer to prison is rarely employed, but is a necessary safety-valve arrangement.

Another code section that violates, in a minor way, the principle that I am suggesting is the law that makes it mandatory that a narcotic addict be held at least three months. It is theoretically possible for a hospital-destroying criminal psychopath to be committed under this section; the hospital superintendent is then powerless to correct the matter. He cannot discharge the patient as not insane because he is not committed as such, and he cannot return him to court.

The procedure that violates the principle more notably is that dealing with the criminally insane — not the group who are too psychotic to stand trial, but those who are held not guilty by reason of insanity. This is the group that is convicted of no crime but must be held in the hospital at least one year. They occur in this state at the rate of about four male patients a month. When such a patient is psychotic, of course he belongs in the hospital, but there are some of these who, although with personality disorder, are not psychotic and there are some who recover their sanity within a short time after admission. Should the latter have rioting tendencies, it is legally impossible to correct the situation. The only practical "out" is to prosecute such a non-psychotic patient locally, should he commit a felony (e.g. assault on an attendant) while in the hospital.

At the present time in California nearly all offenders who are held "not guilty by reason of insanity" are amenable to the hospital setting. However, with the tendency to modify the McNaghten rule, we shall need to study our procedures for selecting for hospitalization non-psychotic offenders with personality disorder. As our success with the sexual psychopaths indicates, there are such cases who belong in the hospital rather than the prison setting. I have tried to outline why I believe it would be impractical and unwise to hold these non-psychotic offenders legally irresponsible for their offenses in order to commit them to the mental hospital. Such a procedure precludes us from later transferring such a patient to prison should he be unamenable to the hospital setting. Present indications are that the non-psychotic offender who apparently should be in the state hospital rather than in prison should first, as with the sexual psychopath, be convicted, and then sent to the state hospital. The superintendent would then be able to return him to court for sentence or recommitment to a prison facility, should he be found unsuitable for the hospital program. Any offender held to be "not guilty by reason of insanity" should be psychotic, and the superintendent should have the power to release him when recovered, just as he does with the other mentally ill.

HUSBAND-WIFE HOMICIDES

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MOST homicide literature does not analyze the relationship between victim and offender, but instead concentrates attention on either the victim or the offender. As a result, a static structural analysis of homicide is usually presented that fails to take cognizance of the dynamic elements in the social situation. The relationship between victim and offender is of special importance in this crime. Homicide is a dynamic phenomenon between two or more persons caught up in a life drama where they operate in a direct, interactional relationship. More so than in any other violation of conduct norms, the relationship the victim bears to the offender plays a role in explaining the reasons for such flagrant violation. All offenses against the person involve direct contact between victim and offender, but homicide usually means a greater degree of intensity or longer duration of this contact than is true for any other offense. Those slayings in which a husband kills his wife, or vice versa, represent the most personalized nature of the crime of homicide.[1]

There is, unfortunately, a paucity of studies and of data that describe and analyze husband-wife homicides. In his review of 100 males committed to the Massachusetts State Prison on conviction of homicide, Stearns[2] noted that eight had killed their wives. In *The Illinois Crime Survey*[3], Lashly reported that, of 760 killings during 1926 and 1927, the Chicago police recorded 55 husband-wife slayings. Arthur MacDonald[4] pointed out that in England and Wales between 1886 and 1905, of 487 murders committed by men, 26% of the victims were wives of the slayers. More recent statistics from England and Wales may be found in the Report of the Royal Commission on

1 This study is part of a larger work on patterns in criminal homicide to be published by the University of Pennsylvania Press.
2 Albert W. Stearns, "Homicide in Massachusetts," American Journal of Psychiatry 4 (July 1924-April 1925), p. 740.
3 *Illinois Crime Survey* (Chicago: Illinois Association for Criminal Justice and the Chicago Crime Commission, 1929), p. 610.
4 Arthur MacDonald, Death Penalty and Homicide, American Journal of Sociology 16 (1911), pp. 96-97.

Capital Punishment[5], which reveals that, between 1900 and 1949, 20% of the 1,080 males convicted of murder had killed their wives. In contrast, only 10% of the 130 females convicted of murder had murdered their husbands. German statistics for 1931 cited by von Hentig[6] supply some brief information regarding husband-wife slayings. Of all male relatives who were victims of murder, 14% were husbands killed by their wives; and of all female relatives who were victims of murder, 62% were wives killed by their husbands. Finally, in a recent study by Albert Kurland and his associates[7] at Spring Grove Hospital in Maryland, it was reported that, of 52 psychotic murderers, 12 were men who had killed their wives and two were women who had slain their husbands. Beyond these few studies, there is very little information reported by students of criminology.

THE PHILADELPHIA STORY: METHODOLOGY

THE present study is part of a larger work which includes analysis of 588 consecutive criminal homicides recorded by the Homicide Squad of the Philadelphia Police Department between January 1, 1948 and December 31, 1952. All told, there were 621 offenders and 588 victims; the number of offenders being larger than that of victims because in several cases more than one person was responsible for one homicide. In husband-wife slayings the relationship always involved one victim and one offender.

To safeguard against loose generalizations, the chi-square test of significance has been used wherever cell-size of the variables being tested permitted such treatment. The conventional use of a P value of less than .05, or the 5% level of significance, has been employed as the limit of statistically significant association. Therefore, whenever the term *significant* is used in italics, the reader may assume that a test of association has been made and that a chi-square with P less than .05 has been found.

RACE AND SEX

Of the 136 victims who had a familial relationship to their slayers, there were exactly 100 husbands or wives, 9 sons, 8 daughters,

5 Royal Commission on Capital Punishment, 1949-1952 Report (London: H.M. Stationery Office, 1953), p. 330.
6 Hans von Hentig, The Criminal and His Victim (New Haven: Yale University Press, 1948), p. 392.
7 Albert A. Kurland, Jacob Morgenstern, and Carolyn Sheets, A Comparative Study of Wife Murderers Admitted to a State Psychiatric Hospital, Journal of Social Therapy 1 (Jan. 1955), pp. 7-15.

3 mothers, 3 brothers, 2 fathers, 1 sister and 10 other types of more distant relations. The primary focus of attention in the present study is with the 100 mate slayings. Of these, 53 wives were slain by their husbands, and 47 husbands by their wives. *Significantly*, the number of wives homicidally assaulted by their husbands constituted 41% of all women who were killed, whereas husbands homicidally assaulted by their wives made up only 11% of all men who were killed. Among those killed by a spouse, Negro husbands numbered 40, Negro wives 40, white husbands 7, and white wives 13.

When a man was killed by a woman, he was most likely to be killed by his wife. Of 75 Negro males slain by Negro females, 40, or 53%, were husbands slain by their mates; and of 9 white males killed by white females, 7 were slain by their mates.

When a woman committed homicide, she was more likely than a man to kill her mate. Of 89 Negro female offenders (for whom a victim-offender relationship has been identified), 40, or 45%, killed their husbands; and of 15 white female offenders, 7 killed their husbands. On the other hand, of 321 Negro male offenders, only 40, or 12%, killed their wives; and of 118 white male offenders, only 13, or 11%, killed their wives.

Combining the races, we may note that when the 104 identified female offenders committed homicide, they killed their husbands in 45% of the cases; but when the 439 identified male offenders committed homicide, they killed their wives in only 12% of the cases.

VIOLENCE

ALL criminal homicide implies that some kind of violence has been employed and that the death was not a natural one. But some slayers kill their victims with one shot, one stab or one blow; while other offenders brutally and much more violently kill. It may be a purely arbitrary and statistical artifact to attempt to draw quantitatively a line between violent and nonviolent homicide, but the study by Berg and Fox[8] provides some useful insight into this problem. These authors, like the present one, consider two or more acts of stabbing, cutting or shooting, involved in the process of slaying a victim, as violent homicide. If a severe beating is the method by which the victim met death, it too may be classified among violent homicides,

8 I. A. Berg, and Vernon Fox, Factors in Homicides Committed by 200 Males. Journal of Social Psychology 26 (Aug. 1947), pp. 109-119.

although determination of a severe beating is probably a more subjective evaluation by the researcher. If more than five acts were involved in the death, the slaying may properly be labeled "excessive violence." Although previous analysis in the larger work, which is concerned with all 588 cases, showed no positive association between the intimacy of interpersonal relationship and violence of the homicide in general, there is a *significant* association between violence and spouse slayings. Husbands killed their wives violently in a *significantly* greater proportion than did wives who killed their husbands. Among the 53 husbands who killed their wives, 44 did so violently, but among the 47 wives who killed their husbands, only 18 did so violently.

The excessive or severe degrees of violence in which more than five acts were involved were most likely to have a home for the scene, and of all violent homicides, 18% involved more than five acts of a stabbing or shooting. However, among husband-wife homicides, the category of "more than five acts" constitutes 24% of all violent mate slayings. Thus, husband-wife homicides were violent to a greater degree than homicides in general. To this extent, violence and intimacy of personal relationship are associated.

PLACE AND METHOD

WITH respect to place of occurrence, 85% of husband-wife slayings occurred in the home and only 15% outside the home. The single place where most of these slayings occurred was in the bedroom. Arguments, emotional conflicts, tensions that arise before a couple enters the bedroom, are ordinarily resolved to enjoy the primary purposes of the room, which are sleep and sexual intimacies. The primary purposes appear to become secondary, however, for most persons involved in husband-wife homicide. In those cases where the interpersonal conflicts are carried into the bedroom, or that arise there in the first place, the sleep or sex drive that conducted the couple there becomes subordinated to the tension issues between them. Thus the physical proximity of husband and wife, required largely by institutional expectation in the case of sleep, and of biological necessity in the case of sex, provides a setting in the bedroom for unresolved conflicts. Most women who kill, as we have seen, kill their mates, and since they are not generally in direct contact with their husbands during the working hours of the day, it is not unlikely that when domestic quarrels, pangs of jealousy or desire for revenge arise, they should occur during the evening hours and, if unresolved, are taken into the

bedroom. Sex differentials are important to this generalization about the frequency of bedroom homicides. Whereas 24 (45%) of the 53 wives were killed in a bedroom, only 11 (23%) of the 47 husbands were killed there. Thus, proportionately and *significantly*, the bedroom is a more lethal place for wives than for husbands.

With respect to the kitchen, a reverse situation appears to be true, for only 10 wives were slain there compared with 19 husbands. Wives usually stabbed their mates, as indicated by the fact that 30 wives used this method to kill their husbands and only 15 shot them. Husbands were less discriminatory, and killed their wives in almost equal proportions of the leading methods. In 19 cases they shot their mates, in 16 they stabbed them, and in 15 beat them to death. Of the 45 wives killed in the home, 17 were shot and 15 were beaten; of the 40 husbands killed in the home, 23 were stabbed. When a husband was killed in the kitchen, his wife usually used a kitchen instrument (a butcher knife or paring knife most commonly) which was easily accessible. This fact indicates that most kitchen slayings were committed in the heat of passion, during a quarrel and on the spur of the moment. Mealtime is one of those family rituals[9] often used for discussion of problems affecting the individual members of the familial group. As a frequent family meeting place; as a place for family discussion during which tempers may rise and frustrations accumulated during the day may find vent among primary group members; as a place where wives raise questions about the family budget and suggest that their husbands are spending too much money on liquor and perhaps other women, and as a place where butcher knives and other deadly weapons are handy, the kitchen more often than any other room in the home provides a setting for women who kill their husbands.

Of the husbands killed in a kitchen, 17 were stabbed with a kitchen knife and only 2 were shot. Of the wives killed in a kitchen, 5 were stabbed with a kitchen knife, 3 were shot, 1 was beaten to death with a broomstick and 1 was severely cut with a hatchet. Of 11 husbands killed in a bedroom, 4 were stabbed with a kitchen knife, 4 were shot with a pistol, 1 with a shotgun, 1 was cut with a jagged drinking glass and 1 was soaked with kerosene and burned to death. Of 24 wives killed in a bedroom, 9 were beaten or strangled, 6 were stabbed with a kitchen knife, 4 were shot and 1 each was slain by a

9 James H. S. Bossard and Eleanor Boll, Family Ritual (Philadelphia: University of Pennsylvania Press, 1950), p. 99.

mop handle, an electric iron, an iron pipe, an overdose of barbiturates and a push from a third-floor apartment. Among these wives killed in a bedroom there were 12 beatings, 6 stabbings, 4 shootings and 2 by miscellaneous methods. When a husband was killed in any place in the home other than the kitchen or bedroom, his wife used a pistol in 4 cases, a shotgun in 1, a penknife in 3, a kitchen knife in 2. When a wife was slain in any place in the home other than the kitchen or bedroom, her husband used a pistol in 9 cases, a shotgun in 1 and a penknife in 1.

VICTIM-PRECIPITATED CASES

IN the analysis of criminal homicide in Philadelphia, the term *victim-precipitated* homicide applies to those homicides in which the victim is a direct, positive precipitator in the crime.[10] The role of the victim is here characterized by his having been the first in the homicide drama to use physical force directed against his subsequent slayer. The victim-precipitated cases are those on which the victim was the first to show and use a deadly weapon, to strike a blow in an altercation—in short, the first to commence the interplay of resort to physical violence. In seeking to identify the victim-precipitated cases recorded in police files, it has not been possible always to determine whether the homicides strictly parallel legal interpretations of sufficient provocation to reduce a murder charge to one of manslaughter. In general, there appears to be much similarity. Mutual quarrels and wordy altercations do not constitute sufficient provocation under law, nor are they included in the meaning herein applied to victim-precipitated homicide. The victim, in these cases, must be the first to resort to physically assaultive methods of attack.

Of the 550 identifiable relationships between victims and offenders among total homicides in the larger study, 150, or 26%, have been designated as victim-precipitated homicides. An impression derived from analysis of husband-wife slayings inferred that a higher proportion of husbands than of wives provoked their mates into killing them; that is, first struck their mates and changed the level of social inter-

10 For some theoretical suggestions on the role of the victim as a determinant in crime, see Hans von Hentig, *op. cit.*, pp. 383-450. For excellent legal discussions of the rule of provocation, see: Rollin M. Perkins, The Law of Homicide, Journal of Criminal Law and Criminology 36 (March-April 1946) pp. 412-427; and Herbert Wechsler and Jerome Michael, A Rationale of the Law of Homicide, reprinted from Columbia Law Review 37 (May and December 1937), especially pp. 1280-1282.

action from that of verbalizing to assaulting. Of 38 family slayings among victim-precipitated cases, 33 are husband-wife killings, while of 98 family slayings among non-victim-precipitated cases, only 67 are husband-wife killings. This proportional difference results in a *significant* association between mate slayings and victim-precipitated homicide.

Of these victim-precipitated mate slayings, 28 victims are husbands and only 5 are wives; but of non-victim-precipitated mate slayings, only 19 victims are husbands while 48 are wives. Thus, there is a *significant* association between husbands who are victims in mate slayings and victim-precipitated homicide. This fact—namely, that *significantly* more husbands than wives precipitate their own demise in spouse slayings—means that (1) husbands actually may provoke their wives more often than wives provoke their husbands to assault; or (2) assuming that provocation by wives is as intense and equally as frequent, or even more frequent than provocation by husbands, then husbands do not receive and define provocation stimuli with as great or as violent a reaction as do wives; or (3) husbands may have a greater felt sense of guilt for one reason or another, and receive verbal insults and overt physical assaults in a marital conflict without retaliation as a form of compensatory punishment; or (4) husbands may withdraw more often than wives from the scene of marital conflict, and thus eliminate temporarily a violent overt reaction to their wives' provocation. This is only a suggestive, not an exhaustive list of probable explanations. In any case, we are left with the undeniable fact that husbands more often than wives are major precipitating factors in their own homicidal deaths.

DISPOSITION OF OFFENDERS

The following breakdown shows the disposition according to marital status of offender:

	Husband	*Wife*	*Total*
Guilty	34	26	60
Not Guilty	2	16	18
Nolle Prosequi	2	2	4
Pending	3	2	5
Suicide	10	1	11
Died Before Trial	1	—	1
Fugitive	1	—	1
Total	53	47	100

Below is the court designation of the homicide according to marital status of the defendant:

	Husband	*Wife*	*Total*
First Degree Murder	10	—	10
Second Degree Murder	10	4	14
Voluntary Manslaughter	10	15	25
Involuntary Manslaughter	4	7	11
Total	34	26	60

These data reveal that:

(1) a higher proportion of husbands (64%) than of wives (55%) were found guilty;

(2) a higher proportion of wives (34%) than of husbands (4%) were acquitted;

(3) more husbands (19%) than wives (2%) commited suicide after having killed their mates;

(4) husbands were convicted of more serious degrees of homicide than were wives. The majority of husbands were convicted of murder while five-sixths of the wives were convicted of manslaughter. None of the wives, but about a third of the husbands, were convicted of first-degree murder. Less than a sixth of the wives, contrasted with three-fifths of the husbands, were convicted of either of the degrees of murder.

An immediate and common conclusion from these data suggests that the courts treat wives with greater leniency than they do husbands. Such an interpretation of differential treatment assumes that all other things are equal—i.e., there is no major difference in the actual types of homicides committed by wives and husbands. Examination of these mate slayings reveals, however, that it is not necessarily true that the courts treated wives with unjustifiably greater leniency than they did husbands, for in 28 cases of female defendants, the husband had strongly provoked his wife to attack; and, although she was not exonerated on grounds of self-defense, there had been sufficient provocation by the husband (as the victim) to reduce the seriousness of her offense. In contrast, such provocation recognized by the courts occurred in only 5 cases in which husbands killed their wives.

FINALLY, it is interesting to note that in only one of the 47 cases in which a wife killed her husband did she later commit suicide; but that in 10 of the 53 cases in which a husband killed his wife did

he commit suicide.[11] Close examination of mate slayings ending in suicide implies that this differential is due to greater feelings of guilt and remorse on the part of husbands. We know from previous analysis of victim-precipitated mate slayings that 28 husbands and only 5 wives were victims who contributed to their own death by making the first assault. The wife who killed her husband after he had slapped or beaten her is less likely to feel remorse or guilt than if she had not been so provoked. Husbands killed their wives *significantly* more often without provocation. These facts suggest that husbands had greater guilt and remorse feelings and hence more frequently committed suicide after slaying their mates.

11 If the 10 husbands who killed their wives and then committed suicide had killed themselves in the same proportion as wives, the number of husbands convicted of first degree murder would have been much higher. Judgment of these 10 homicide-suicides of husbands, by competent observers, places them in the first-degree murder category. Should the cases have gone to trial, likelihood of conviction for murder would have been great.

HUSBAND-WIFE CRIMINAL HOMICIDE, BY RACE, METHOD, PLACE AND VIOLENCE, PHILADELPHIA, 1948-1952

	Husband Killed by Wife	*Wife Killed by Husband*	*Total*
Both Races	47	53	100
Negro	40	40	80
White	7	13	20
Method			
Stabbing	30	16	46
Shooting	15	19	34
Beating	—	15	15
Other	2	3	5
	47	53	100
Place			
Bedroom	11	24	35
Kitchen	19	10	29
Living Room	4	7	11
Stairway	6	3	9
Highway (public street, alley, field)	4	4	8
Taproom	2	1	3
Other commercial place	1	3	4
Other	—	1	1
	47	53	100
Violence	18	44	62
Non-Violence	29	9	38
	47	53	100

PRECRIMINOLOGICAL PROBLEMS

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ANYONE who is concerned in the preventive or correctional aspects of antisocial behavior is bound to be fully alive to the depth of changes that have come about in the last ten years in the world picture and in the mental horizon. Besides, it is often difficult for the oldsters, who are called upon to devise the clinical approach to these problems, to understand the tensions with which the different facets of culture obsess particularly the younger generation. We meet in our day, as much as in the past, the problem of the responsibility, the question of the meaning of life and the need of ideals. All the same, it is as if there is something changing, which we must understand if we are going to discern sufficiently the possible trends in the life of the individual and the community.

There is yet so much in evolution in our rapidly changing and continually new world of experience that it is hardly possible to discern the essential value in the ideological power that is bearing all this. The indeterminate and unseizable spirit in this tremendous happening gives a feeling of insecurity and restlessness, inviting full tension. We are now, as in the days of Augustine, in the struggle for enduring cultural values, for inner harmony and for all that is good and true. One may think that religion and philosophy here have the responsible leadership and must answer these questions. But modern man is often unable to obtain satisfaction from these and, in fear and uneasiness, he turns to the physician. And this is the field of psychotherapy: the treatment of the modern human being in his attitude of hopelessness. He finds nothing to hope for in life, has no faith in the future and turns to momentary stimuli, as to a drug: excessive smoking — especially cigarettes — the cinema with sensational films, alcohol or other stimulants, sexual excesses whether in the form of onanism or of prostitution. But none of these temporary stimuli is capable of satisfy-

ing the longing for personal fulfillment. As a rule those who come to us are the best of their kind. The fact that they come, in their tension or overstrain, to the psychotherapist is a favorable sign, showing that they have not yet completely given up hope.

The fact that it is just our time that is characterized by such an enormous number of neurotic persons is connected with the spiritual problems of our days. Every period has had its own neuroses. The nervous disorders of today also bear the stamp of the mental structure of our time. But in our period there is a particular feature that requires further examination.

Throughout the ages man has lived with the idea of salvation and has found serenity in the hope of salvation belonging to his time. We see this very clearly in the Oriental religions of the Babylonians and Assyrians and later also in the Greek and Roman concepts of the Saviour and of salvation. Whether the expectation was eschatological — looking to a permanent state of bliss — or of a cycle in which the present state would recur, we always find that it contained the anticipation of salvation. Nebuchadnezzar's dream, in which the history of the world is depicted symbolically in four eras: the golden, silver, copper and iron eras, and Pharoah's dream — to keep to examples from the Old Testament — must be regarded as reminiscences of this living in the expectation of salvation.

Hesiod relates how the ancient Greeks (in the eighth century B.C.) believed in a meeting-place of the dead where they existed happy and free from care. There was an active belief, a desire to join this throng in the course of time. There all bonds with the world of men and earthly suffering were broken. At a later date the ideas changed. The multitude of the blessed dead ceased to grow and in the writings of Homer life after death is seen as a doubtful blessing. It was as though the soul deprived of its body lost its power and consciousness. In the Homeric beliefs it was, indeed, possible for the gods to elevate mortals also to immortality in their kingdom, but the isles of the blessed were visible only on the farthest horizon. The gods acquired human characteristics and the poet Sophocles cried out in protest: "Nowhere does Apollo's honor remain untarnished. Gone is the service of the gods." What remained was the memory of the time when the souls of the dead had attained a higher, eternal life. But the age of the heroic sagas passed and in the last century before Christ there seemed to be no other solution than self-preservation, resignation and prudence. A pessimistic view of life.

ALTHOUGH religion dried up in this period — the ancient religion was no more than a sort of pact with the gods — although the deities of Olympus were nothing more than fossils, subsequent research has shown that among the masses an active faith lived on, influenced by Oriental mysteries. There are innumerable indications that in the Greco-Roman world, before the spread of Christianity, the longing for salvation and for a Saviour lived in the hearts of the people. This yearning, which was often accompanied by the conviction that the fulfillment was close at hand, was in many cases characterized by the expectation that a divine being would come to cleanse the world and bring it salvation. This longing sprang, not from a sense of the misery of the individual spirit, but from the expectation of the advent of a communal happiness in which the individual would participate.

This sense of community was strong in the ancient world, belief in the social group, belief in the state which was not only a political unit but also — and above all — a unit of religion and culture. The expectations of salvation were universal and world-embracing in character. This is clearly seen at a later date, in the last century B.C., when the hope and belief in the coming of a God-man existed, as Virgil tells us in his fourth eclogue. Here he heralds the coming of a boy who shall bring peace and happiness to the earth. At a later period, when the Emperor Augustus made an end of wars and internecine strife, he was acclaimed as the promised messenger, religion became a Caesar-cult. But it soon became obvious that attempts on the part of the state to direct the religious sense into its channels have no significance for the individual human being; they are incapable of satisfying his need for personal salvation.

In the same way as there remained among the Greeks — independently of the pact with the gods — a belief in salvation, in the state religion of Augustus we can also detect an undercurrent charged with the anticipation of salvation — a personal sense of sin and a yearning for absolution from these sins and the attainment of salvation for time and eternity. Numerous are the signs pointing to the existence of such hopes: "A shuddering expectation of salvation passes through the soul of the heathen world."

Then came Christianity with our Saviour and filled with the hope of salvation. Let me make this clear. Christianity is not the resultant of heathenism and an adaptation to the needs of the time in a flash of genius, but it does show a far-reaching analogy, as regards the doctrine of salvation, with what had stirred the hearts of men

for many centuries. In Hellenistic piety this was often no more than a romantic-religious mood, in which however many found serenity. Where the underlying ideas had crystallized out, it appeared again and again that the *personal* longings remained unsatisfied. There is no reason to believe that the idea of absolution sprang from the soil of Hellenistic piety — the Saviour and the expectations of salvation of the heathen world remained without fulfillment. But if we are to understand the tensions of our age, it is worth our while to note how for many centuries, both in Greco-Roman culture and later, up to the Middle Ages, not only the life of the individual but religion and philosophy found their origin and their culmination in the expectation of salvation. This came to an end in the middle of the eighteenth century. The Christian church had lost her hold on the minds of men. Enlightened thinkers asserted that joy and blessedness were not things for which one must hope in the future.

The eschatological element was banished from the theories on life and happiness. The heralds of the French Revolution succeeded in abolishing the Saviour and salvation concepts, which had occupied the mind of man through the ages. But this does not mean that they were without faith. Theirs was a belief in the perfectability of humanity. Such a faith was that of Rousseau, believing that when man unfolds his power in freedom, joy and blessedness will be his part. Such a faith was that of Robespierre, a follower of Rousseau's "new Christianity," which the latter had formulated in the well-known creed of the Vicaire Savoyard. Such a faith was that of August Comte, who firmly believed that man's reason guaranteed him the summit of happiness.

This period, wherein man believed in himself and trusted to his reason, lasted until about the middle of the last century. It is not possible to state exactly when it came to an end. The philosopher Hegel still belonged to this period and so did Karl Marx at the beginning of his career. Hegel was so fully convinced of the perfectability, of the final state of bliss that the individual human being could attain, that it seemed as though there was no more left to strive after or long for. With Hegel — said one of his critics — the summit has been reached; for us there is nothing further to be attained.

Marx is better known to us as the man who concerned himself with changes in economic life. But behind this was the idealist of his time: man carries within himself the power to blossom out into ideal happiness. What prevents him from doing this is the external state

of affairs. Hence the enthusiasm with which he set himself to improve social conditions.

After this second period, which in contrast to the first with its duration of many centuries, gave activity and relief to the human spirit for only seventy or eighty years, came the third.

Whereas the first period was marked by a belief in a Saviour and salvation and the second by its belief in mankind, this third period took as the object of its faith an idea, that of evolution.

Development will bring happiness: not for each individual human being is happiness in store, but this state will be reached through a slow process of evolution. Evolution had brought mankind to its present state; evolution had made the world as we knew it. Evolution would bring us to the gates of bliss. And man believed in evolution and in the causality associated with it. And he continued in this belief until the first decades of this century; but happiness did not come.

Belief in evolution is finished. We still hear of it but are no longer stirred by it. Science still works with this concept, but it has lost its grip on the mass of the people. We have lost faith in evolution.

WHAT remains? Here we have the problem of our time. What is the meaning of existence, the object of life? Religion and philosophy were supposed to provide the answers. But their answers no longer satisfy modern man. For him religion is long dead and philosophy withered. The expectation of a Saviour is a thing of the distant past, but now the belief in mankind and in development to better times has vanished too. Truly, they are not the superficial souls that suffer shipwreck on these rocks; who are unable to believe because this means a leap in the dark, who have no hope because life has disillusioned them, who with better skepticism doubt the sense of their existence and the value of their lives. Rousseau at least believed in something, even if his faith was in himself and in matter.

Darwin believed, even if his belief was in the law of cause and effect in evolution.

Freud believed in something, even if his faith was initially in the *"ichgemässe Entfaltung"* of the human personality.

And even nowadays his disciples believe that it is possible by means of scientific thought to learn something about the reality of things in order to increase happiness by directing our lives toward this.

And all these people, these psychotherapists, who do their best every day to give relief to those who come to them in fear and

agitation, also state their belief — or, to use their own cautious expression, *"uns hat immer die Ahnung gerührt"* — that behind the multitude of minor passions and longings lies hidden something serious and awe-inspiring that we may approach only with the utmost diffidence.

In this way the modern psychotherapist tries to help those who come to him for aid. For they all want the same thing: comfort, a possibility of hope, faith: the wildest revolutionaries not less passionately than the truly pious believers.

A man came to my consulting room: one of the most valued members of the staff of a large hospital; he had been a good student and a hard worker. For years he had given counsel and support to others, to his parents and other relatives. He smoothed away difficulties—also gave financial aid where this was needed. He had broken off his engagement because he saw in it elements that were not according to the will of God. He had judged and condemned, also where it was not necessary.

But at last he broke down, was unable to hold unto his ideals and became a victim of our time. He began to suffer from insomnia and headaches, dreamed of things he did not wish to dream about and was perpetually tortured by fear. And when he came with all these complaints to the doctor it transpired that he had lost his faith; he had no trust in God or man, no hope for the future and no more confidence in himself.

Another example: A woman who came to me for treatment some years ago for general complaints—restlessness, insomnia, compulsive actions, discontent with her own life. She had a responsible, leading position in a spiritual movement. She was a woman with a strong sense of duty and respect for her mother; charitable, never unkind, always helpful and an active philanthropic worker. But against this she showed an inner rebellion against her mother and her environment. There existed a fierce conflict; compulsive actions were present. Here there was an *"übermoralische"* tendency that she was unable to maintain. Thus she presented herself as a patient, as one who felt that inability, and then proceeded to go to the other extreme. For instance, she wrote: "I get on very well in my new attitude to life"; "at any rate it's a relief not to try any longer"; "he who is willing to lose his life etc. . . . "; "I wonder if this will work better"; "can't you help me to be consistent? I want self-expression but am too great a coward for it. In theory I say: do what you want to do; go your own way; even if you land in the gutter—at any rate

you live." She had a habit of scratching herself and wrote, "and now I only hope that my skin will give way, then blood poisoning will finish me off." Next time she wrote: "I don't believe anything any more. As I left you I was overwhelmed by despair. Perhaps I had been expecting the absolute again, as I used to do, in any case I had hoped to go home beaten, broken or whatever you like to call it, and instead of that I was still standing bolt upright. Is there any sense in trying any longer; have I not killed all feeling stone-dead and is it not better to resign myself to this? For a time it was still a kind of struggle between God and my cynicism. I see now that I have given up the struggle and cultivated my cynicism. A great passion may bring me to life, but somehow I can't bring myself to that. Even for that I haven't enough depth of feeling. I can easily address a meeting, so as to reduce them all to tears—I can create an atmosphere, feel the thawing power of sentiment and transmit this to others too. Just as myself-conceit expresses itself in humility, my intellectualism expresses itself in emotion. But my faith has gone—my feeling is dead and life is futile".

Finally a letter from a man in the thirties: "It is a long time since I last wrote to you. Self-defense! For I ought to come and see you and dare not, because when I write to you the longing to speak to you again grows much stronger and it is not possible for me to do so. But there are times when I want so much to talk in order, by speaking out, to get some order into the chaos of my thoughts. For I am getting lonely in spite of plenty of work and regular social intercourse with a number of people. For a year now I no longer have a real friend and I miss that more and more. I would give a great deal to find someone who cared about me and in whom I could feel more than a superficial interest. But what depresses me the most is the lack of prospect." Life without feeling, without hope, without faith.

THIS is the situation of modern man in a life without expectation of salvation, without hope. He has ceased to expect anything of life. He has lost confidence in science; he has lost confidence in himself. Many such people come to the nerve specialist, either of their own despair or urged on by their relatives. First they have tried to drug themselves with stimuli: excessive smoking, drugs, free intercourse and other sexual stimuli. But love and faith have gone. They have no bonds with the past, no historical sense; they know no con-

tinuity and have no prospect. They are unable to sleep, lose weight, feel miserable and restless and cannot work. Weariness of life and attempts at suicide are common.

It is as though none of the three earlier periods has any grip on the human being of today. The expectation of salvation is no longer there, nor is the belief in oneself, and the belief in causality and evolution has gone the same way.

This period of rebellion, on the one hand against the old faith and on the other hand against intellectualism and mechanization, was already casting its shadow at the turn of the century. Nietzsche and Dostoyevsky, each in his own way, was a herald of this time.

It is a fact that with this decline of historical and religious life, with the disappearance of the religious structure, the neuroses are on the increase. And this increase is more marked in the better educated and in those not professing any religious belief. Few simple pious souls come to us for treatment. Just where life dissolves into the "hopelessness" of our time and religion has lost its influence do we find the neuroses. Especially now that the belief in perfectability, the ideal human being and the ideal state and the belief in progress have disappeared.

Thus the question of treatment of neuroses and of many psychopathic conditions is a profoundly far-reaching spiritual anthropological problem. The individual has suffered an injury to his soul and seeks aid from the physician. For this reason the nerve specialist is compelled to occupy himself with questions that belong actually to the fields of theology, psychology and philosophy.

If the therapist is content to banish the feelings of fear and guilt without asking himself whether disintegration and sinfulness are not essential parts of the human pattern, he performs a pneumatic or "noetic leucotomy."

With the elimination of the religious urge and the ethical religious structure, the highest spiritual needs of humanity have been suppressed. In our terminology we speak of repression. Our age is suffering from the repression of values that are important for spiritual life. This is manifesting itself particularly in the field of criminology and psychopathology of delinquency. Re-education and reorientation of spiritual possibility then are an exceptionally difficult task. It requires a numerous and expert staff of psychiatrists and nursing establishment. If it is possible to meet these requirements, then it is already evident that in this field, too, favorable results may be expected.

PSYCHOANALYTICAL APPLICATIONS OF PSYCHODRAMA

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PSYCHOANALYSTS cannot encounter psychodramatic techniques without using them and without applying their theoretical and technical conception to this aspect of psychotherapy.

However, Moreno, in his papers about psychodrama, frequently underlined the differences between psychoanalysis and psychodrama. According to his point of view, this last variety of psychotherapy is a more elaborated and a more efficient one than analytical verbal psychotherapy.

As far as we know, only few works have been devoted to a synthesis between psychodramatic techniques and the theories upon which psychoanalytical techniques are based.

In the United States, Martin Goldberg, Peter A. Dumas, Samuel Dinenberg and William Winnick, in a recent paper entitled "Comparative Effectiveness of Analytic and Psychodramatic Group Therapy with Psychotics,"[4] point out the actual importance of this contrariety.

In France our own work, as well as that of our co-workers in this field, has systematically been switched in this direction.

In this paper we shall first try to justify this contrariety between psychodrama and psychoanalysis. Then we shall proceed to show in which direction the psychodramatic techniques tend and how they can be applied.

Generally speaking, the history of the development of psychoanalysis justifies the apparently radical contrast between this kind of psychotherapy and psychodrama. Indeed, if Freud, in the beginnings of analytical therapy, insisted upon the effects of "catharsis"[2] a word borrowed from the Greek theatre, the entire further development of

psychoanalysis directed toward the structural, topic and dynamic study of the ego has driven him to a verbal technique of studying transference and resistance. The therapeutic relationship is limited to a verbal one which, of course, is laid upon a strong emotional current validating all abreactions denoting the evolution of the treatment; but as a basic principle the patient gives up all nonverbal ways of expressing himself and "acting out" is systematically reduced and elucidated by interpretation as being a form of resistance.

As a matter of fact, this short survey of the evolution of psychoanalysis does not exclude the application of derived techniques that are not necessarily verbal: the psychoanalytic treatment of young children handled through game techniques is already close to psychodrama.

On the other hand, it is always difficult to locate with precision the borders of psychoanalytical techniques, because psychoanalysts are still arguing about this matter and don't always agree on its criteria (Glover)[3] and also because many of them are using psychoanalytically oriented psychotherapies that they do not sufficiently distinguish from genuine psychoanalysis.

With Nacht, we find that a definition of psychoanalysis cannot be given through the use of a "ritual technique," but appears through a process involving transference and resistances (Nacht and Lebovici).[16] The criteria of such a psychotherapeutic technique are not necessarily limited to an exclusive verbal experience.

Moreno[13, 14, 15] always asserted psychodrama was a better technique than psychoanalysis. The main points of his thinking can be found in a series of remarks preliminary to his review, "Group Psychotherapy." In this discussion connections between transference, counter-transference and "tele" are studied, as well as the role of unconscious and acting out.

GENERALLY speaking, Moreno asserts that patients are improving a great deal in passing from the psychoanalyst's couch to the stage of the "theatre of spontaneity." This improvement is due to the fact that the patient really expresses himself. Besides, Moreno wants to see not only the couch given up, but also the general orientation of analytical theories and terminology. About the unconscious, Moreno writes[14]: "The system of the unconscious as proposed by Freud and extended by Jung is weak in its foundations. It is logically inconsistent, incomplete and, from a research point of view, unproductive. The link between the preconscious and unconscious is not satisfactorily ex-

plained. The link between the preconscious and unconscious of an individual and of another individual is entirely missing and there is a gap between the individuals, the small groups and the collectivities to which they belong. The whole area of unconscious psychic activities needs to be reformulated within an operational and activistic frame of reference".

In the discussion following Moreno's papers, a few authors attempted to build up a synthesis of the various methods of psychotherapy and William J. Warner[18] did it in the most successful way. The different methods of psychotherapy are considered as a deepening and a maturation of interpersonal relationship. As a matter of fact, some psychoanalysts did describe the treatment as an emotional experience both maturing and correcting, and transference as a modality of a therapeutic anhistoric relationship. As far as we are concerned, in our contribution to the discussion established by Jacob Moreno[9], we attempted to justify the conceptions of psychoanalytical theories in the field of classic psychoanalytical techniques as well as in its psychodramatic application.

It is essential now to point to a fact of importance, on which I do not quite agree with Dr. Moreno's work. The emergence of the transference neurosis is not related to the ritual of psychoanalytic treatment. The psychoanalyst's couch is not a necessity. Of course, psychoanalysts agree that the technical conditions of treatment induce the patient to regress. The patient who is maintained in an infantile position tends to transfer his drives and defenses on his analyst.[12]

However, every psychotherapy in which systematic frustration is wilfully maintained gives rise to transference neurosis. The existence of child psychoanalysis is the best proof of it. In the same way, as in psychoanalytical psychodrama, this frustration is desired, planned and should keep the interplay well balanced. The adult psychoanalyst "should not play the game," as Fenichel puts it. The child psychoanalyst, as well as those using psychodrama, *should play the game and yet not play it.*

In such conditions, we can understand the transference effects in every interpersonal relationship. Ezriel and Sutherland[1] underlined this fact: transference is an *"hic et nunc"* experience to which Kurt Lewin's theories can be referred. For these authors, psychoanalysis is an *anhistorical and nongenetic experience.*

In a paper on group psychoanalysis,[4] we started from premises laid by these authors, then we pointed out that the origin of trans-

ference can be found in the interpersonal relationship process. In individual psychoanalysis, the therapist keeps a warm, noncommittal attitude and does not respond to his patient's requests. In a group, patient A displays behavior X with patient B. B responds by behavior Y, thus playing a role that responds to role X. In individual psychoanalysis the patient's behavior consists of assigning a role to his analyst; his simultaneous refusal and acceptance of this role are the basis for the transference reactions. We find here the concept of role as described by Moreno in interpersonal relationships. As far as transference is concerned, it should be called *"the assumed role."*

The great importance of counter-transference can now be perceived. However, counter-transference is not the response the psychoanalyst gives to his patient's transference, since by definition the psychoanalyst must refuse to cathexise his patient as a transference object. Counter-transference is the total emotional attitudes of the analyst who has to face the necessity of assuming a role. Consequently the psychoanalytic treatment cannot be conceived, as suggested by Dr. Moreno, as being an interplay of transferential and counter-transferential elements. Transference is related to the psychoanalytic situation. If the psychoanalyst assumes it correctly, he can, by the means of his counter-transference (spontaneous or oriented), bring the transference neurosis to a solution.

In conclusion, every interpersonal relationship can include transferential and counter-transferential elements. But these elements do not cover the total extent of this relationship. They are only privileged in the psychoanalytic experience. The psychotherapeutic relationship, considered in its more extensive aspect includes relational expressions other than the transferential ones. Dr. Moreno's tele belongs to these extra-transferential processes and can be used as he suggests. However, an inexperienced psychotherapist, relying on the *"Zweifühlung"* experience, takes the risk of leaving transference hidden. In some cases, not too severe ones, such a technique is useful. When a psychoanalytic cure is recommended because of a severe neurotic or pre-psychotic condition, this technique may be dangerous.

WE cannot discuss in detail here, the second problem raised by Moreno, that is the problem of the unconscious in psychotherapy. Let us at least recall that the aim Freud assigned to psychoanalysis, "to bring to consciousness what was unconscious," is far from being achieved in practice. To use the always convenient psychoanalytical

topics, psychoanalysts work more on the ego than on the id. It is the unconscious part of the ego that becomes evident in the resistances: they are expressing the ego defenses. In the framework on the interpretations concerning transference and resistances, one achieves a release of these defenses: this release allows the integration of some repressed and actually useful drives. Fantasy, in adult as well as in child psychoanalysis, is a privileged tool in our work. Now, transference is only the elaboration—in the interplay of transferential and counter-transferential relationship—of unconscious material.

Psychoanalysis cannot be reduced to a study of fantasies. However, we must ponder over this matter, since it could lead us to admit the usefulness of a comparison between psychoanalytic and psychodramatic methods. With R. Diatkine[8], we pointed out that fantasies are a *dramatic* unfolding of our past life. However, we know that psychoanalytic aims consist in integrating these fantasies into transference, avoiding having them acted out. Psychodrama requires that the patient's fantasies be acted out. Child psychoanalysis remains in the same perspective to the extent that it relies on play techniques.

However, it should be recalled that in psychoanalytic theories the patient's acting out is extra-transferential: it is a running away from transference. In dramatic as well as in child psychoanalysis, the dramatic production of fantasies is lived within the transferential relationship. Our opinion in this technical framework is that some psychotic patients who do not respond to classical psychoanalytical technique can be treated through the dramatic production. On the other hand, we think we had good reasons to write that dramatic group therapy—by producing common fantasies—finally achieves the slackening off of the relationships within the group, since they are artificial because of the therapeutic structure of the group. In other words, we believe that the dramatic action, as far as therapy is concerned, cannot be considered in the same way as the psychoanalytical acting out: we think that the interpretation of the transferential phenomenon is most useful to maintain a level of therapeutic dramatization.

These few lines show the great importance we have attached to Dr. Moreno's contribution. According to us, psychodrama has become a first-rate tool for diagnostic and therapeutic use. However, we think we could integrate our knowledge concerning psychoanalytic theory and technique in our psychotherapeutic action, and particularly in the psychodramatic one. Such scrutiny, far from leading to rejection of either one of the theories, allows us to extend our views and to increase

the number of patients we accept with reasonable expectations of success.

Hereafter, we cannot dissociate our adult and child analyst experience from our psychodramatist experience.

These few remarks bring us to the matter of our own experience in the field of psychodramatic psychoanalysis.

I—*About the Use of Dramatic Phenomena*

Starting from our own experience in the field of child psychoanalysis, we first thought that expressing conflicts through games could be advantageous for patients. Dramatic catharsis can indeed be very helpful in some cases, as for instance in severely inhibited patients who are incapable of expression on a verbal level.[5]

But soon the simple dramatic expression classified by Moreno under therapeutic "acting out" appeared to us to have possibly the same meaning of acted-out resistance as the one assigned by psychoanalysts. For instance, we frequently see patients cured through psychodrama who imagine that they are dealing with a learning technique that will enable them to think they get away from their shyness and court women. According to them, therapists are only assistants in the acting of learning scenes.

In these conditions we usually interpret such an attitude as a resistance: the patient finally knows there will not be any sexual intercourse between one of his therapists and himself and it is easy to point out to him that his desire of acting out is nothing other than a resistance meant for fighting against transference love, in making sure that the therapist, as well as others close to him precisely want to help him in his own realization.

This technical aspect of psychodramatic acting out seems to point out in an understandable way that such a therapy does not justify, but even excludes, the complicated technique of setting up a psychodramatic theatre, which can only favor this kind of resistance.

At last, the setting up of the psychodramatic scene can be compared to the elaboration of a dream or a fantasy. It is the dramatic unfolding of a past lived just in the light of successive structurations of the ego.

This theoretical conception does not exclude the importance Moreno deservedly gives to the spontaneity of the dramatic expression that favors the patient's realization by himself. In this way he assumes

his destiny. The warmth of the therapeutic relationship, as far as bodily contact is concerned, is certainly specific to psychodrama and happens to be specially helpful for some ages (mainly with adolescents) and for same cases (psychotics).

But the considerations about the means of dramatic expression in the field of psychotherapy have to be complemented by some precisions concerning the theoretical foundations of the therapeutic relationship underlying these ways of expression.

II—*Study of Psychotherapeutic Relationship in Psychodramatic Psychoanalysis*

The ritual of classic psychoanalytic treatment, and mainly the systematic attitude of frustration, imposed by the therapist induces to regression and emphasizes the organization of the transference neurosis for which and through which the patient asserts his resistance.

The situation, as far as psychodrama is concerned, is much more complicated. When group psychotherapy is concerned, transferential effects spread out to the other group members upon whom agressivity, for instance, can be more easily expressed. In the same way the assistant therapists are objects of transferential displacements. Dynamic mechanisms directing the constitution of transference neurosis spread out through this displacement.

The necessarily active attitude adopted by the group of psychotherapists also plays an important part in the specific structuring of transference. However, we may assert that the therapist's behavior has to be the psychoanalytical position shifted to a dramatic level.

Recalling the importance of Fenichel's classic definition of the analyst's ideal attitude, "not playing the game" may appear as a paradox where dramatic psychoanalysis is concerned. Now, right away, more or less obviously, patients ask the therapist for direct help. Abstaining from entering into the game, and consequently decreasing the profits patients may derive from their neurotic position, is a most important point. Expressing the patient's requests in the game and at the same time refusing any affective participation must be the psychoanalyst's main worry.

But as we just pointed out, if we can talk about a transferential displacement with its specific dramatic psychotherapy modalities, the therapist's important neutral attitude also involves specific aspects of this therapeutic situation: (a) The constitution of a group of therapists

makes the exteriorization of deep negative feelings toward the patient dangerously easy; (b) Refusing to play the game the way the patient proposes inflicts a narcissistic wound: it is a recall of the disdain parents so frequently express about children's games. Psychodramatists often avoid the anxiety involved in the therapeutic situation either through an histrionic attitude denounced by Moreno, or through an aggressive attitude painfully felt by the patient.

III—*Handling of Defense Mechanisms*

The defense mechanisms of the ego, securing the balance between pulsions and object cathexis, play their part in dramatic psychoanalysis. They even assume such importance that patients soon realize their efficiency and their rigidity. A simple example, pointing out the efficiency of psychodramatic therapy in the indispensable therapeutic work tending to soften the ego mechanisms, may be found here.

Gilbert is 17 years old. He is under treatment because of intellectual inhibitions severely affecting his schooling. When depicting his relationship with his father through the psychodramatic process, he shows that his father's only contact with him consists of asking about, commenting upon and blaming his son for his school marks. A typical Oedipus situation becomes apparent, since Gilbert introduces an auxiliary character representing his mother, to whom he gives a pacifying part in his conflicts with his father. In a second stage, Gilbert is asked to imagine his own behavior in the future when he will be a father himself. A secondary datum is the fact that he gives his future wife his mother's first name. But the main point is that, in playing his part of a future father, Gilbert freely chooses to be another father whose only relationship with his son is considered under the aspect of criticism and blame. This defense against aggressiveness toward his father, determining so complete an identification, could not miss striking the patient. We can see from this example how easy and efficient the elucidation of defense mechanisms can be through the psychodramatic technique.

Another kind of defense mechanism can be treated successfully with psychodromatic therapy: those that we felt we could call after other authors' psychotic defense mechanisms[10]. It appears through many processes that this kind of patient is fighting against disintegrating anxiety in using mechanisms tending toward a fusion with the object. This mechanism is called projective identification. In the psychodrama-

tic realization, this defensive process appears in a research of close contact on an "anaclitic" basis with therapists. In such a case the patient tries to fuse with the therapist so that he can avoid having a disintegrating and fragmenting relationship. Such is the case of a patient who has been treated by psychoanalytical psychodrama because he wanted to become a woman. As a matter of fact, he has the almost delusional belief that he has "a woman's soul in a man's body." This belief is connected with his fear of being attacked by a woman who in his fantasies eats and incorporates his penis. In the scenes that were acted out, the patient always tried to show his good relationship with women who got along well with him and approved him in his desire to be changed into a woman. But in a scene in which he imagined an argument between himself and a woman colleague, his fear of having an erection and consequently of provoking an aggression by this woman appeared. Thus the reason for his refusal to play the scene first planned and his desire to adopt a conciliatory attitude toward the auxiliary character who played the colleague part in the aggressive way he first asked for. The patient was defending himself against the fear of bodily attack by the means of psychotic mechanisms in looking for fusion. As we can see, this mechanism could easily have been explained and analyzed by means of psychodramatic realization.

THIS brief study of the handling of the defense mechanisms helps give a better understanding of the aspect of *the object relation.*

First of all, as we have seen in the dramatic expression of conflicts, the psychodramatic technique allows a rapid bringing together with the therapist, who happens to be the support of a particularly energetic object cathexis. It is always amazing to watch adolescents and adults, who probably can do it in an easier way than adolescents, expressing their conflicts on the therapeutic stage under the protection of the dramatic fiction. The bringing together with the therapist, the shortening of the distance kept by the patient toward the objects and mainly with the psychoanalyst, appear according to many authors as being the main foundation of the emotional phenomena that are indispensable for the process of an analytical psychotherapeutic treatment.

This bringing together appears quite soon in psychodrama and we may wonder if it is not similar to the one observed by psychotherapists practicing the "symbolic realization" method.[17]

On the other hand, through psychodrama patients soon become

strikingly aware of the kind of object relation determining transferential as well as extra-transferential behaviors. In this matter we constantly use two techniques proposed by Moreno. Both appear to be quite successful in helping patients to identify with their objects.

(a) *Reversal of roles*: Fundamental technique. We saw its interest in Gilbert's concern. In many cases the only first possibility of expression on a psychodramatic level consists of assuming a parent image. Such is the case of Patricia, aged 9. Her behavior was described as being that of a perverse child. All attempts to get in contact with her failed. She started expressing herself in the psychodramatic situation, first on a simple motor level, miming a ball game. When asked to play her mother's part, she easily drew a picture of an over-aggressive mother who put no limit on punishing her. Thus she shows off the masochistic character of her relationship with her mother and the efficiency of her superego. Her understanding of the importance of the object relation modality is rapid and specially useful.

(b) *The mirror technique*: Very helpful with psychotics. With these patients we know, through the fusion defense mechanism, the importance of specular phenomena justifying the therapeutic utilization of mirror effect, that is to say the representation the patient has of himself. In the case of a 9-year-old boy, who materialized in a quasi-delusional way, his picture seen in the mirror showed signs of a severe infantile psychosis. The use of the mirror technique, the research of fusion with his duplicate from whom he feared aggression, were of course severe troubles of the body image, but were also helpful in the therapeutic process.

(c) with delirious and hallucinated patients we usually cautiously materialize their auditive hallucinations under an aspect recalling the *Greek tragedy choir*. This technique has the great advantage of pointing out to the patients the connection between their hallucinations and the object images of their phantom world.

We believe that, far from being a simple acting out (in that way it is rather a resistance factor), the psychodramatic treatment should progress through transference neurosis modeled by resistances expressing the ego defenses. This can be done only through the well-balanced counter-transference attitude the psychotherapist adopts under the protection of working through elaboration. These technical necessities explain the specific terminology we use for cures of this kind.

Group Dramatic Psychonalaysis

In this case a group psychotherapy is concerned. The treatment by dramatic technique tends to explain the specific group transference phenomena. It is important to observe that this means of psychotherapy is only accessorily a socio-therapy, the treatment group existence being closely connected with the therapeutic situation. Although the group members' improvement and recovery can show in their social readaptation, the dramatic realization helps the interpretive reconstitution of the common group fantasies, and this through diverse displacement. These displacements are easier from a member of the group to another one than to therapists.

Patients treated for diverse neurotic conditions (six to eight patients of both sexes when adults, same sex when adolescents, with a well-balanced cultural and dramatic level of expression aptitudes) are invited to agree about the story to be acted. The well-known dynamic phenomena happening during the process of group psychotherapies, will be used up to this point: the specific point concerning the dramatic tool is the way patients do or do not assume the parts they first accepted. Transferential displacements appear through the roles patients give to therapists (two or three most of the time). This group therapy technique can be compared to young child psychoanalysis devoted to work on the child's fantasies, the part of the ego being obviously reduced as far as actual reality is concerned. It is, however, an interesting variety of psychotherapy, either for neurotic patients whose verbal expression of affects seems impossible, or for inhibited ones.

Psychoanalytical Psychodrama

This is a more onerous technique, since a single patient requires the presence of a group of therapists to carry on his treatment. Treatment is directed according to psychodramatic rules; the scenes to be acted are proposed by the patient but can be replayed or modified at the psychoanalyst's request. The psychoanalyst assumes the direction of the psychodrama, but if possible he should not participate to the dramatic realization. This technique is valid only in very severe cases, severe neurotic or pre-psychotic patients or behavior disorders observed in borderline subjects. Thanks to the specific part-reversing technique, to the mirror technique and to the tragedy choir, psychodrama allows

awareness of the primitive defense mechanisms of the pre-psychotic kind. The dramatic realization favors the removal of severe inhibitions and makes the deep interpretive working through possible in a well-balanced atmosphere of neutrality tempered by the affective warmth this atmosphere allows.

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To punish and not prevent is to labor at the pump and leave open the leak. —*Thomas Fuller*

The growing infirmities of age manifest themselves in nothing more strongly than in an inveterate dislike of being interrupted.
—*Charles Lamb*

"Rotten Eggs"

A DISTINGUISHED judge, whose name is familiar in overworld and underworld alike, recently offered an unorthodox argument for the segregation of incorrigible young offenders. Many of the youthful criminals who troop in and out of courts and prisons are "rotten eggs," he asserted, and if they were mixed into the general penal population they would soon corrupt their elders. Therefore, the jurist argued, these young criminals should be concentrated in special institutions as a quarantine against spreading their contagion.

As an example of what he meant by a "rotten egg," the judge described an adolescent who had come before him. At the age of 14 this youngster was a "mainliner," adept at injecting heroin in the vein of his arm with a medicine-dropper. At 15 he was a "pusher," making his illicit living by peddling narcotics. At 16 he was in custody for a major crime. It was not enough that such a hoodlum should be locked up, according to the judge; he should be immured where he could not infect others less contaminated.

The fact that our jurist's dictum constitutes an exact reversal of the usual corrective concept is of course a part of the device of paradox with which he sought to dramatize his point. Yet the prevailing tone of his discourse illustrates the fallacy of much of the judicial standpoint on crime: an inability or unwillingness to look at its pathological aspects. Plainly the young offender cited began by committing a crime against himself when he reached out for narcotic support against his basic malaise; then he exemplified his ethical distortion when he preyed upon others' addiction for sordid gain; finally he revealed his dual grievance against himself and society when he committed a crime both to vent his hatred and to invoke punishment and, thereby, succour. When will we begin to look at crime as what it nearly always is — an outcry against the torment that accumulates in so many miserable beings from sources beyond their understanding and control.

But let us not be swept away on this perennial wave of revulsion toward the wrongdoer. How many persons who face the bar of justice for the commission of crime are incontrovertibly "rotten eggs"? We know that the proportion is not large. Yet the percentage is high enough to inject a major difficulty in any comprehensive or long-range

program for the rehabilitation of early or casual offenders. Public and official impatience and resentment toward deliberate criminals is perhaps the greatest obstacle to effective aid for those who, for less patient reasons, stray into trouble.

And what makes a "rotten egg" anyway? In the jurisdiction of the judge here quoted, in common with many other teeming urban communities, the answer is obvious. Anyone who has gone into the Tobacco Roads of a big city need not wonder how or why they produce so many worthless offspring. There jumbled clans of the migrant and immigrant horde exist in unspeakable squalor, packed eight to a dozen in each room of filthy hovels. Indifference and promiscuity are such that it is seldom clear who is whose mate or what is the paternity of the brawling children. Principles of honesty and morality are hardly even implied. A modern Hogarth could not adequately picture the chaos of confused degradation in which thousands of these miserable people eke out their lives. It is here, in most cases, that the "rotten eggs" come into being. So long as we merely wait for them to come into court as criminals, and do nothing meanwhile to prevent their spawning, their number will naturally continue to multiply.

In other words, we labor in futility at the wrong end of the scale. While we continue to think of the crime problem in terms of courts and prisons, lock-ups cannot be built fast enough to contain the candidates for them. If we permit the embryo of crime to proliferate in unheeded slums, have we the right to complain of its material and social cost? If we allow migration and immigration to go unregulated without provision for decent housing and social services, we are simply abetting human misery and inviting the certainty of ever-expanding crime.

Meanwhile, if we have nothing better to look forward to but the old prison system, a pragmatic device would be a division of such institutions into maximum-security lock-ups for the appointed "rotten eggs" and therapeutically-oriented centers for others convicted of crime but reasonably susceptible to rescue. Let us be on guard against the cynical suggestion that, because many prisoners are irredeemable, concern for the others who may be helped is illusory and impractical.

In any event, the problem of the "rotten egg" points up anew the basic premise of all community improvements: prevention, not remedy, is the only effective formula; unless social adaptation begins with the child, in the home, in the school and by any other available agency, we shall continue to have temporizing palliatives but no cure.

The Stigma of Psychiatry

ONE of the far-reaching effects of the increasing complexity of life is the growth of the stigma unjustly associated with psychiatric treatment. A tendency to equate such treatment with mental conditions that stamp the patient as undependable or suspect apparently has raised imagined or practical obstacles in a considerable number of cases.

Yale University has made it known that, because of students' objections, it omits psychiatric records from questionnaires for the selection of applicants for graduate and professional schools and government agencies. Some students have rejected psychiatric guidance for fear of putting on record data that might interfere with their careers. Such questions as "Has the student ever consulted a psychiatrist?" are now considered to be "loaded."

This indicator points to a condition that all of us who are associated with psychiatry would do well to face frankly. In the first place, the necessary growth of institutional psychiatry, in the armed services, in other government services, in colleges and the like, has given rise to much haphazard consultation that can hardly be described as adequate. Inevitably the doctor in many cases has insufficient rapport with the patient to do justice to his function. When such brief or piecemeal contacts are translated into cold record, the data, even though accurate, may give a misleading impression to an uninitiated third party. It could conceivably be unfair to use such material as a basis for judgment.

Second, the extreme importance attached to security factors in Washington during and after the war cast a certain suspicion on such ailments as fell into the psychiatric category. Many persons in contact with that situation were conditioned to interpret any suggestion of psychiatric consultation as an evidence of potential undependability. An acute manifestation of this atmosphere occurred in the widespread impression that homosexuals were shielded from sensitive positions because of their assumed vulnerability to blackmail.

Third, the chronic shortage of qualified practitioners, as we have observed before, has resulted in opening the field to many whose qualifications and performance have been less than ideal. Moreover, many young physicians have taken up psychiatric practice with less education and clinical experience than such a role rightfully demands. It is probable that more shadow has been cast upon the specialty from this source than from any other. After all, the measure of any profes-

sion is to be found in the character and probity of its representatives.

Fourth, it would appear that psychiatry is not yet old enough to have outlived the traditional irrational odium clinging to mental illness. We have yet to persuade at least a great part of the general public that mental ills are essentially no more dreadful than most physical ailments.

All these elements are part of a situation of which most psychiatrists are continually conscious. So long as the physician is able to maintain his contact with his patient on a generally confidential basis, the optimum benefit is obtained. In institutional and underqualified practice, even when ethical scruples are maintained, the tendency of some patients to suspect that confidence is not complete can become a soure of painful difficulty. These are problems for which psychiatrists and their associates must continue to evolve working solutions.

Bogus Bomb Scares in Schools

SCHOOL authorities in various parts of the country have been plagued by a virtual epidemic of mischievous bomb scares. The chain of expensive nuisance appears to have been started by a youth who, to cover his truancy, telephoned anonymously to his school that a bomb was hidden in the building. The stratagem worked so well that classes were suspended for most of the day. In the rash of imitations that followed, someone telephoned that a bomb was hidden in an unspecified one of the many schools of suburban Westchester County, New York. Not only was 130,000 pupils' study interrupted, but police and fire services were immobilized in the needless search for explosives.

These absurd incidents may perhaps be explained partly as foolish pranks and partly as egocentric thoughtlessness. They also suggest the contagious quality of a harebrained practical joke, possibly inspired by a television thriller. But the questions they raise are pertinent to the condition of today's youth. What kind of youngster would be prompted to indulge in or copy such mushrooming mischief? What lack of home or community guidance would account for his inconsiderate delinquency?

When a lurid film gave currency to the phrase "blackboard jungle," a debate arose as to whether accenting the peccadillos of a

few malicious youths libeled the great majority of earnest school children. The moderate view is that heterogeneous classes in large schools have always contained a few uncouth and even vicious youngsters, reflecting the blight of their environment. Yet most teachers and other adults do not recall that their school days were marked by episodes so extreme or bizarre as some we read of nowadays.

There is strong evidence in the over-all conduct of youth not only that children are more exuberant, virile and volatile than those of earlier generations but that many of them are more self-centered and less conscious of the truism that effort is the price of satisfaction and reward. Children in general are so surfeited with modern privileges and ease-bringing gadgets that they have become impatient of the hurdle between any wish and its gratification. There is no doubt that if the essential qualities of effort, patience and discretion were better inculcated there would be less delinquency.

The other day a man who had succeeded by his own efforts stopped his car behind a gleaming school bus while it took on children at the doors of their homes. "I wonder," he mused, "what takes the place in these children's lives of the four miles I walked to and from school each day."

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The Ambivalent Muse

And last, but not least, I would like to thank my husband, without whose unfailing and invigorating discouragement this book would never have been written.

—From acknowledgments in Julia Wadham's
The Case of Cornelia Connelly

To my dear wife, without whose absence this book would never have been written.

—Jean Dutourd, in *The Taxis of the Marne*

BOOK REVIEWS

Helen Keller — Sketch for a Portrait

Van Wyck Brooks, E. P. Dutton and Co., Inc., New York, 1956

THIS is a book of high romances which leaves behind it a glowing track of good things. Written in comely and, at times, very lyrical prose, it is a luminous biography of the eager quenchless spirit who is Helen Keller. Van Wyck Brooks leads us persuasively through the early childhood and "no world" of this prodigy where there was no hope or wonder or faith or joy into the miracle of her unfolding because of the wisdom and genius of Anne Sullivan. Through this remarkable woman darkness became for her a smiling light, a constant invitation for life to laugh and show Helen its wondrous treasures. Anne Sullivan made creation sing for her. In an unforgettable picture we see the little girl, deaf, blind and unable to speak, discovering herself, "as if I had come back to life after being dead . . . delicious sensations rippled through me, and strange sweet things that were locked up in my heart began to sing."

Thus the book is largely the story of Dear Teacher (Helen's own phrase) whose dream it was to deliver the image from the stone. Half-blind herself and fourteen years older than Helen, Miss Anne Sullivan entered upon the great work in 1887, "feeling her way into a method of her own." Distrusting elaborate systems of education, she knew instinctively that children needed guidance and love far more than instruction. She *knew* how corrosive were the elements of pity and over-protectiveness for the handicapped, and never praised Helen unless her work equalled the best a normal child might achieve. Observant and brilliantly critical, Anne's achievement, one feels, came from extraordinary intelligence and an unbelievable devotion.

Much later on, Miss Keller reflected as her own "clairvoyant

hands" rippled over Rodin's *The Thinker* that this was how "Teacher hewed my life, bit by bit out of the formless silent dark."

The book abounds in sharp and dramatic images. There is the thrilling discovery in the beginning when Anne holds Helen's hand under the spout and the little girl connects the word water with the cool stream. There is the discovery of the philosophic mind at twelve when Helen's mind travels to Greece but her body has not left the room! There are the college days, with Anne rapidly spelling the lectures into Helen's hand, and Helen that night reading Greek "till the tips of her fingers bled."

Once the vivid intelligence of Helen Keller had been released into the blue and the morning by Dear Teacher, she progressed by leaps and bounds. Simple, direct, vital, she entered upon her work for the blind and the handicapped. Her will was iron and drove her to incredible achievement.

Though determined to regard the world as a bright and lovely place, she was aware of its deep shadows. (Anne had seen to that too.) Thus we find her grieving over catastrophes in the news, — dust storms, floods, wars. She hated race intolerance with its meanness and folly. She had the deepest compassion for the handicapped and underprivileged.

In her travels it would seem that she met almost every person of consequence in the last two generations — Mark Twain, Einstein, Dean Howells, Jo Davidson, Van Dyke among others. "All of them felt in her presence wonder, compassion, tenderness and awe." And after the sad death of Anne Sullivan Macy there came the vivacious and dramatic Polly Thomson, an extraordinary teacher also and a warm companion.

One puts down the book with regret. For teachers and psychologists it shows what may be accomplished by the one who loves and understands the dignity of the human person. For the handicapped it is a call to greatness.

Van Wyck Brooks' short but pertinent commentary in the closing chapters merits close attention. The great and spacious days of this lovely woman give an answer to the black thinking in the world today, bred of false philosophy and materialism. Let us be reverent, he says in effect, before the mystery of the human mind and affirm the goodness existing in the world.

BROTHER C. EUGENE, F.S.C.

Midwest and Its Children: The Psychological Ecology of an American Town

Roger G. Barker and Herbert F. Wright, Row, Peterson & Co., New York, 1954

ROGER BARKER and Herbert Wright, who are regarded as having contributed significantly to Lewinian psychology and toward the application of scientific procedures in the study of behavior, make the claim that this book represents the first detailed analysis of the living conditions and behavior of all the children of a community.

To identify the implication of the naturally occurring everyday behavior and the psychological world of children, the Barker-Wright team worked among the children of "Midwest," a small town that exhibits in rather pure form a segment of the American cultural scene. In this town of 707 residents, the daily activities of 119 children under 12 years of age were carefully observed, recorded and codified over a period of five years.

It is the hope of the authors that this report of their work will spur others to map out the psychological ecology of other communities so that psychological situations will be as well mapped as the physical areas or the economic levels of the world. Of significance is the outline and readability of the research. The authors have planned the organization and format of this volume with the interests of the specific type of reader in mind. A panorama of the problems, methods and findings of the investigation are presented in the first and final chapters. The middle chapters are highly detailed. Fifty-six pages of appendices and index present the collected data that will interest the more critical reader.

That this work is well planned, well executed, and admirably presented cannot be emphasized enough.

As an indication of the completeness of this study are presented only a small number of the more than 100 behavior settings that were surveyed. Among these are school classes, traffic ways, grocery, locker and feed stores, motor vehicle sales and service, drug, variety and department stores, indoor entertainments, restaurants and taverns, government and school offices, home appliance, hardware, implement and furniture stores, attorneys', insurance and real estate offices, indoor

athletic contests, building contractors and material suppliers, hotels, rooming houses and nurseries, telephone and electric offices, barbers and beauticians, hallways, coatrooms, out-of-door athletic contests, banks, factories etc.

This volume represents a work of scientific value because it adds significantly and without ambiguity to the base of behavioral data, which is the source from which progress may be achieved in science.

BENJAMIN S. ALIMENA, Ph.D.

The History of Capital Punishment

George Ryley Scott, Associated Booksellers, Westport, Conn.

IF one were to search for the least worthy fibers of human nature, where would a baser strain be found than in the taking of human life under cover of legal sanction? The rueful story of capital punishment begins with the practice of blood-revenge, invoked by aggrieved relatives in primitive times, and comes down to the state-controlled gallows, guillotine, electric chair and lethal chamber. Though the evolution of this ultimate penalty has cloaked it with society's assent, the ancient aspect of savagery and primal anger cling to it still, investing the citizens responsible for it with a burden of uneasy guilt. For it is clear in the history of man-dealt annihilation that the condonation of murder has always fired the cruelty of the callous and troubled the consciences of the humane. The principal difference between the headsman's block and our supposed refinment of it is that the responsibility once assumed by a tyrant king is now shared by all of us. Rationalize and sophistically justify it though we may, the truth is that no reflective person is satisfied with the perpetuation of this barbaric remedy for grievous offenses.

Mr. Scott has infused into his gruesome chronicle a sobering estimate of capital punishment's ancillary aspects: its brutalizing effects upon those who must administer and execute the death penalty, as well as upon those who witness, even vicariously, its shocking finale; the self-evident fallacy of the notion that it deters crime by invoking the potential criminal's fear for his life; the real possibility of taking an

innocent life by error, and other often-debated points. But his strongest argument against legalized murder resides in his factual catalogue of the methods used down through time to destroy vindictively those who have incurred society's displeasure. He cites the medieval technique of drawing and quartering as the most ghastly of these spectacles; yet he permits one to wonder whether that protracted agony was so much more cruel than the ordeal of the condemned person who waits months and even years for the day of his "humane" extinction to arrive. Like other forms of sanctional retribution, capital punishment gives way only slowly to the erosion of enlightened action because the public attitude toward crime and criminals is so complex a tangle of ambivalent emotions that most of us prefer to let the subject lie domant. Mr. Scott's bibliography lists 110 books of exposition and controversy in this field. And, even after the protracted torrent of debate thus reflected, how much has the old order changed?

The Urge to Punish

Henry Weihofen, Farrar, Straus & Cudahy, New York, 1956

ONE significant aspect of this ponderable book is the fact that its author is a lawyer who persuasively pleads a cause that lawyers in general have been reluctant to espouse: a rationally humane approach to the problems of criminal law enforcement. That an attorney of his eminence should commit to print so sweeping an argument for the viewpoint long promoted by social therapists is a revealing indication of recent epochal progress toward a meeting of minds on this sorely controversial question.

Mr. Weihofen is Professor of Law at the University of New Mexico. His book is based upon his lectures delivered at Temple University under the Isaac Ray Award of the American Psychiatric Association. The text of these six dissertations is supplemented by an extensive appendix in which he documents his argument with citations from a wide array of impressive sources. These notes alone provide an illuminating commentary upon the focal questions.

The book's title and thesis hinge upon the basic difficulty of controlling crime—the irrational, emotional and unconscious factors that creep into the public's fearfully vindictive attitude toward transgressors. "It is not only criminals who are motivated by irrational and emotional impulsions," Mr. Weihofen reminds us once more. "The same is true also of lawyers and judges, butchers and bakers." Nor is this peculiar to one field; "all social science research is likely to have its data colored and its propositions distorted by fear and prejudice, for religious dogma, ethical concepts, social outlook and economic interests are likely to be deeply involved."

With penetrating analysis and illuminating example Mr. Weihofen exposes the defects of Dr. Ray's rule and the McNaghten rule and marshals proposals for a truly progressive penal code. His exposition of the anachronistic injustice of much penal procedure, and of the futility of capital punishment, builds up an indictment based largely upon the atavistic aspects of the psychology of punishment—man's instinctive fear of his neighbor and the projection of such fears in unconscious or rationalized forms of aggression.

His conclusion is succintly expressed in his own peroration: "With the help of insights that psychiatry and psychology are giving us into how the mainsprings of human behavior operate, we are learning much about how to bring up children to fit into the world. Perhaps we are also learning how to build a world fit for them to live in. With these insights we are better armed for the task of molding a society that nurtures the healthy and fruitful growth of individual life, a society that holds inviolable the dignity of man and fosters love and understanding of one's fellow man rather than hostility and aggression—a society, in short, that respects life."

If this book could be made required reading for every prosecutor and judge, the lingering obstacles to an intelligent administration of justice would not prevail much longer.

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THE basic value of our civilization is, in Adbert Schweitzer's phrase, Reverence for Life. Indeed, a good measure of any civilization is the extent to which this seminal concept is valued and implemented. If we want to inculcate respect for human life, we must not ourselves take life in the name of the law. —*Henry Weihofen*

WORLD OF SOCIAL THERAPY

Air Pollution—Smog will put New York and other big cities in the plight of London and Los Angeles within ten years if precautions are not maintained, warns Dr. Leonard Greenburg, New York Commissioner of Air Pollution Control.

Apron Strings—Cutting the apron strings is the most difficult problem faced by young college students, according to a survey made in California colleges and universities. This dilemma was found accentuated by the recent upward trend of undergraduate marriages.

Arson—Eight persons died in a Cincinnati fire set by a rejected suitor to destroy the building where his former girl friend lived.

Borrowers—When the Elizabeth, N. J., library declared a book-fine amnesty for a day, more than 1,000 books were returned. One woman brought in a shopping cart full.

Capital Punishment—Britain's restriction of the death penalty, proposed in place of abolition, is expected to reduce the average number of hangings to about four a year from the fifty-five year average of thirteen, according to government estimates. It is intended to confine capital punishment to murders by professional criminals and the killing of agents of law and order, as well as those by shooting and explosions, these being associated with gang warfare and political terrorism.

Community Services—Robert Felix, director of the National Institute of Mental Health, cautions mental hygiene authorities on the neglect of liaison in locality services. He finds many staff members well trained in working with psychotic patients, but poorly informed on working with schools and community agencies.

Darwin—The centennial of Darwin's announcement of the theory of evolution is to be marked in 1958 by a ceremonial duplication of his voyage of the Beagle, with calls at the Atlantic and Pacific islands and South American regions where he made his studies.

Deficient Children—In 150 needy families surveyed by the New York City Youth Board, 330 children out of 825 showed serious behavior problems. Of the remaining children 45% were too young to have been brought to the attention of any agency and it was expected that a large proportion of them also were headed for difficulty if they were not helped.

Desertion—The Massachusetts Public Welfare Administrators Association has asked Congress for a Federal law to put marital deserters in a class with auto thieves. "Disintegration of family life has reached catastrophic proportions," the welfare officials warned.

Gifted Students—The "lockstep" of American education and the "spoon-feeding" of college students are depriving the country of some of its best potential human assets, Clarence Faust, president of the Fund for the Advancement of Education, told a conference of educational leaders. He proposed that superior students be enabled to work independently at as rapid a pace as their capacity and energy would permit.

Headaches—More than 60% of the general population suffers from headache. Those most likely to suffer are medical students, women, people under 20, the unmarried and the divorced or separated. Farmers are the least susceptible occupational group. These are the findings of Dr. Henry Ogden of Louisiana State University in a survey involving 5,000 persons.

Health Hazards—Accidents, the potentialities of atomic radiation and ailments of the aged are envisaged by the American Public Health Association as today's major public health problems, just as the common drinking cup, the roller towel, the housefly and food contamination were fifty years ago.

Judges—Federal Judge Harold R. Medina denounced lawyers who "shrink from battle when it comes to fighting for improvements in the administration of justice." He called upon the bar to come out boldly for qualified judicial candidates instead of merely passing upon those whom political leaders have approved.

Mental Illness—The American Public Health Association estimates conservatively that at least 10% of the people living in big American cities "have one or more of the relatively well-defined mental disorders."

Neurosis—Half of the men receiving medical attention in the Seventh Army in Germany need some sort of psychiatric treatment, Army physicians report. About 1% of the total troop strength is treated each year for psychiatric disorders, and for each of these four or five others are working below peak efficiency.

Police Science—Police Commissioner Stephen P. Kennedy of New York, inaugurating intensive training courses for his higher officers, exhorted them to establish themselves as "social scientists."

Prison Food—When a steward at the Federal Correctional Institution at Danbury, Conn., retired after twenty years' service, 314 convicts signed a petition asking him to remain, declaring he had served "some of the finest meals some of us have ever had in institutions."

Teacher Anxiety—Teachers' personal anxieties too often cause emotional stresses in their pupils, according to a five-year study at Teachers College, Columbia University. Teachers' failure to resolve their own emotional problems results in grouchiness, bitterness, shouting and eccentricity, which evoke hostile complications in the pupils, it was found.

Teen-Agers—Senator Thomas C. Desmond of New York proposes to add at least two teen-age members to the State Youth Commission, now composed of nine adult members.

Vile Man—Man is "the filthiest animal that has ever trod the face of the earth," James Fisher of the Royal Society for the Protection of Birds told the National Audubon Society. A panel of the society advised a long-range study of the effect on human health of the floods of insecticides and detergents reaching water supplies.

Women—Females outnumber males in the United States by about 1,381,000, according to latest Census Bureau figures. The greatest disparity is in the age groups over 25. Six years ago the preponderance of women was only 6,000.

Wonder Drugs—Untoward effects of modern drugs used to control arthritis and rheumatism include insomnia, suicidal depression, impaired judgment, tremors, drowsiness, brain damage, convulsions, delerium tremens, migraine, coma and deafness, reports Dr. Charles A. Brusch of Cambridge, Mass., on the basis of 211 cases tested. He said such therapy left many cases worse off than they were before.

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Bertrand Russell in his new book PORTRAITS FROM MEMORY, published by Simon and Schuster, 1956, commented on his experiences in prison, when in 1918 he was imprisoned for pacifist propaganda, "I was rather interested in my fellow prisoners, who seemed to me in no way morally inferior to the population, though they were on the whole slightly below the usual level of intelligence, as was shown by their having been caught."

A FEW WORDS ABOUT THE AUTHORS

DOCTOR SETTLE, a native of Kansas City, received his M.D. degree from the University of Kansas in 1929, and served his internship at the Kansas City General Hospital. His subsequent professional career has been in the field of correctional medicine and psychiatry. He worked in the Penal and Correctional Systems of Kansas and Wisconsin until 1938, at which time he entered the Public Health Service. His Public Health Service assignments during the ensuing years, have been as Chief Medical Officer at the United States Penitentiaries at McNeil Island, Washington; Terre Haute, Indiana; and currently, since 1950, at the U. S. Penitentiary, Leavenworth, Kansas. He has had a wealth of experience in dealing with adult male felons; was Superintendent of the old Kansas State Hospital for criminal insane when it was an annex of the State Prison, and has been on the Staff at the Medical Center for Federal Prisoners at Springfield, Missouri. He is a commissioned officer, with the rank of Medical Director, in the Regular Corps of the United States Public Health Service, and is a member of the American Psychiatric Association, The American Medical Association, The American Public Health Association, and a past president of the Medical Correctional Association.

DR. MARION R. KING has been superintendent of the Medical Facility, California Department of Corrections, since 1950. Born in Porterville, Calif., he was educated there and at Stanford University (A.D. and M.D.). After commissioned service in the Army Medical Corps in World War I, he entered the U.S. Public Health Service in 1920 and has served as chief medical officer, Penitenitary Annex, Leavenworth; warden and chief medical officer, Medical Center for Federal Prisoners, Springfield, Mo.; medical director, Federal Bureau of Prisons, and medical director, Division of Foreign Service Personnel, Department of State.

DR. CHARLES L. NORD is chief medical officer and psychiatrist at the Federal Correctional Institution, Ashland, Ky. Born in Jamestown, N. Y., he was graduated from Hamilton College and received his M.D. at the University of Michigan Medical School. After a rotating internship at the Highland Park, Mich., General Hospital, he studied and taught psychiatry at the Neuropsychiatric Institute, Ann Arbor. He became head of the Neuropsychiatric Service at the Veterans Administration Hospital, Ann Arbor, in 1953 and received his certification in psychiatry the same year. In 1955 he enlisted in the U.S. Public Health Service, in which he is a Senior Surgeon (R). Dr. and Mrs. Nord and their three children live on the Government Reservation at Ashland.

DR. R. S. ROOD has been superintendent of the Atascadero, Calif., State Hospital since it was opened in 1954. He conceived its basic architectural design. A graduate of Stanford University and the Stanford Medical School, he has been with the California Department of Mental Hygiene for twenty years. During World War II he was a neuropsychiatrist with the Army in Europe.

MARVIN E. WOLFGANG is Assistant Professor of Sociology at the University of Pennsylvania, assistant editor of The Annals of the American Academy of Political and Social Science, and sociology consultant on the study of law and the behavioral sciences at the University of Pennsylvania Law School. His interest in international aspects of crime and punishment has developed from study at the University of Oslo, Norway, and numerous official visits to penal institutions throughout Europe. His article is part of a larger work, Patterns in Criminal Homicide, to be published by the University of Pennsylvania Press.

PROFESSOR LAMBERT VAN DER HORST since 1936 has been Professor-Director of the Valeriusclinic, Amsterdam Free University, where he works with a staff of twenty-six doctors on the central problem of the interaction of psychic and material processes. He also is Professor of Psychiatry at the Amsterdam Municipal University and is head of the psychiatric clinics of both universities. Born in Sneek, Friesland, Dr. van der Horst studied medicine at the University of Groningen, later continued his studies in Tubingen, Munich and Zurich and visited clinics and laboratories in Geneva and at Maudsley Hospital, London. He started practice in Groningen as assistant to Professor E. D. Wiersma. He has been associated with the Valeriusclinic since 1923, was appointed as director of Amsterdam Free University's Psychological and Neurophysiological Laboratory in 1926 and as professor in 1928. Among his many scientific offices, he is president of a committee set up by the Netherlands Government for the treatment of criminal psychopaths.

DR. SERGE LEBOVICI is the first assistant of the Clinique de Neuropsychiatric Infantile of Paris. He collaborates with the Institut de Psychanalyse of Paris, of which he is scientific secretary. Much of his work is in child psychoanalysis and group psychotherapy. For ten years he has taken an interest in psychodrama and its use with integration of psychoanalytical principles and theories.